

Trust Board – Public
Wednesday, 25 March 2020, 11am to 12.30pm

This meeting will be held virtually and video-recorded. Attendance is limited to voting Directors only to allow other Directors to focus on operational matters.

This meeting is not being held in public due to public health risks arising from the Coronavirus. However, members of the public are welcome to forward questions to the Trust Secretariat via imperial.trustcommittees@nhs.net and the questions will be addressed at the meeting and included in the minutes.

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	1.	Opening remarks	Gerald Acher	Oral
	2.	Apologies: Paula Vennells	Gerald Acher	Oral
	3.	Declarations of interests <i>If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting</i>	Gerald Acher	Oral
1105	4.	Minutes of the meeting held on 29 January 2020 <i>To approve the minutes from the last meeting</i>	Gerald Acher	01
	5.	Record of items discussed in Part II of Board meeting held on 29 January 2020 and 25/26 February 2020 <i>To note the report</i>	Gerald Acher	02
	6.	Matters arising and review of action log <i>To note updates on actions arising from previous meetings</i>	Gerald Acher	03
1110	7.	Chief Executive Officer's report <i>To note the report</i>	Tim Orchard	04
For decision / approval				
1125	8.	Business planning 2020/21, including: <ul style="list-style-type: none"> ▪ Priorities for 2020/21 ▪ Financial plan 2020/21 	Jazz Thind, Bob Klaber	05
1135	9.	Sustainable Development Management Plan <i>To approve the plan</i>	Hugh Gostling	06
For discussion				
1145	10.	Bi-monthly Integrated Quality and Performance report <i>To receive the integrated quality and performance report for month 10</i>	Julian Redhead/ Claire Hook	07
1155	11.	Finance report <i>To receive an update for month 11, year to date and other financial matters</i>	Jazz Thind	08
1205	12.	Staff survey results <i>To note the 2019 results, the recommendation actions</i>	Kevin Croft	09

		<i>and the proposed culture work programme</i>		
For noting				
1215	13.	Infection Prevention and Control quarterly report <i>To note the report</i>	Julian Redhead	10
1220	14.	Trust Board Committees – summary reports <i>To note the summary reports from the Trust Board Committees</i>		
	14.1.	Audit, Risk and Governance Committee, 10th March 2020	Gerald Acher	11a
	14.2.	Quality Committee, 18th March 2020	Andy Bush	11b
	14.3.	Finance, Investment and Operations Committee, 18th March 2020	Andreas Raffel	11c
	14.4.	Board Redevelopment Committee, 4 March 2020	Gerald Acher	11d
1225	15.	Any other business	Gerald Acher	Oral
	16.	Questions from the public (as received by email in advance of the meeting)	Gerald Acher	Oral
Close	17.	Date of next meeting Trust Board: 20 May 2020, 11am		

Updated: 23 March 2020

Public Trust Board
Draft Minutes of the meeting held on 29th January 2020
 New Boardroom, Charing Cross Hospital

Members present

Paula Vennells
 Sir Gerald Acher
 Peter Goldsbrough
 Andreas Raffel
 Nick Ross
 Kay Boycott
 Dr Ben Maruthappu
 Nick Ross
 Prof. Tim Orchard
 Prof. Janice Sigsworth
 Prof. Julian Redhead
 Jazz Thind

Trust Chair
 Vice Chair
 Non-executive Director
 Non-executive Director
 Designate Non-executive Director
 Non-executive Director
 Associate Non-executive Director
 Designate Non-executive Director
 Chief Executive
 Director of Nursing
 Medical Director
 Chief Financial Officer

In attendance

Peter Jenkinson
 Prof. Jonathan Weber
 Michelle Dixon
 Bob Klaber
 Kevin Croft
 Jeremy Butler
 Kevin Jarrold
 Claire Hook
 Hugh Gostling
 Prof. TG Teoh
 Prof. Katie Urch
 Dr Frances Bowen
 Ginder Nisar

Director of Corporate Governance
 Dean of the Faculty of Medicine, Imperial College London
 Director of Communications
 Director of Strategy, Research & Innovation
 Director of People and Organisational Development
 Director of Transformation
 Chief Information Officer
 Director of Operational Performance
 Director of Estates and Facilities
 Divisional Director, Women, Children and Clinical Support
 Divisional Director, Surgery, Cancer and Cardiovascular
 Divisional Director, Medicine and Integrated Care
 Deputy Trust Secretary (minutes)

Apologies

Prof. Andrew Bush Non-executive Director

Item	Discussion
1.	Opening remarks Paula Vennells welcomed everyone to the meeting.
2.	Apologies Apologies were noted from those listed above.
3.	Declarations of interests None other than those disclosed previously.
4.	Minutes of the meeting held on 27th November 2019 The minutes of the previous meeting were agreed.
5.	Record of items discussed in part II of Board the Board meeting held on 27th November 2019

	The Board noted the summary of confidential items discussed at the confidential Board meeting held on 27 th November 2019.
6.	Matters arising and actions from previous meetings The updates provided via the action tracker were noted.
7.	Patient story review
7.1.	The Board received an overview of the themes arising from patient stories presented to Board and discussed whether the process was of value and what it would like to do differently.
7.2.	Comments from the Non-executive Directors included that the stories have been valuable but would like to know more about the effectiveness of changes throughout the Trust; what process and criteria was in place to select patient stories; consider using broader sources of patient experience not just a patient story; and staff stories should also be included.
7.3.	Prof. Sigsworth welcomed the comments and would discuss a plan with the Strategic Lay Forum, Executive Quality Committee and Quality Board Committee with a next steps plan to Board in summer. Action: Prof. Sigsworth
7.4.	The Board noted the report and actions arising from the discussions would be taken forward by the Director of Nursing.
8.	Chief Executive Officer's briefing
8.1.	Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership.
8.2.	<u>Operational performance</u> The Board noted the deployment of the command centre technology in the site operations offices noting that this was a first step in a wider programme to digitalise site operations. In terms of performance there had been an 8.5% increase in type 1 A&E attendances in December 2019 compared to December 2018 and staff have been working hard to treat patients as quickly and safely as possible.
8.2.1.	Responding to a question from Mr Goldsbrough about the impact of the new approach to winter planning, Mrs Hook advised that the predictions of pressure have been reasonable with some nuances and early lessons learned, but in the main the process had a positive impact. A full evaluation would be discussed at the Finance, Investment and Operations Committee in March 2020.
8.3.	<u>Finance performance</u> – covered under item 11.
8.4.	<u>Transformation update</u> The Board noted the work underway regarding focused improvements, programmes and projects that would transform into 2020/21 agreed deliverables for the Trust and therefore the content of the Imperial Way architecture. An outline implementation and resource plan would be discussed at the Executive Digital, Strategy and Transformation Committee in February 2020.
8.4.1.	As part of the business planning process, Mr Butler reported that his team had met and received presentations from all of the divisions and corporate departments and feedback on this process had been positive. During February 2020 the Executive Team would prioritise and confirm resource plans for key projects and programmes.
8.5.	<u>Patient focus</u> The Board noted that collaboration work with Chelsea and Westminster (C&W) NHS Foundation Trust was continuing well on developing unified pathways and processes,

	improving quality and cost-effectiveness by reducing unnecessary variation. Current ongoing projects included HIV inpatient services, dermatology and ophthalmology.
8.5.1.	The Board noted the progress between the Trust and C&W NHS Foundation Trust on working together to explore how best to run, organise and develop care for children and young people in North West London.
8.6.	<u>Strategic developments</u> The Board noted the ongoing work piloting new integrated approaches with Primary Care Networks (PCN) to: improve experience and clinical outcomes for patients; improve patient experience, retention and recruitment; reduce per capita spend compared with peer PCNs; improve and expand research and training opportunities; and develop and evaluate a model that was scalable for integrated working across the system. Ms Boycott suggested it would be useful to have a forward view of the testing and ascertain how some of the money could be secured. Prof. Orchard agreed and advised such matters would transpire as the project evolved.
8.6.1.	The Board noted the progress with the Redevelopment Programme of the St Mary's site exploring possible developers, developing an outline business case, funding approaches, and stakeholder engagement. Matthew Tulley starts with the Trust on 3 rd February 2020 as Redevelopment Director who would lead on the strategic redevelopment vision and how the Trust translates that vision into detailed plans. The Board expressed their thanks to Mr Gostling who has covered the Redevelopment Director role for the past year and look forward to his continued and valued input into the programme.
8.7.	<u>People</u> The Board noted that following discussions at the previous Board and the Trust's commitment to reviewing a range of options, the Executive Team had engaged further with Trade Union partners and noted that a decision on how the Trust would provide hotel services from 1 st April 2020 would be confirmed by the end of January 2020.
8.7.1.	The Board noted the actions taken to assist in tackling increased incidences of violence and aggression in the Trust, particularly at St Mary's Hospital.
8.7.2.	The Board noted updates regarding the pathway to excellence programme (covered later in the meeting); end of life annual report; the development of a programme to make the international year of the nurse and midwife celebrating the 200 th birthday of Florence Nightingale; staff survey completion rate which was 11% improvement over the past two years – the results of the survey would be presented to the next meeting of the Trust Board; the flu campaign achieved a 62% vaccination rate thus far, however, much lower than the target of 90%. Responding to Mr Goldsbrough regarding the need to plan more robustly for next year for flu vaccinations, Prof. Orchard agreed and advised that amongst other learning and actions, going forward staff would be contractually obliged to receive the vaccination. Action re. staff survey: Kevin Croft
8.7.3.	Prof. Orchard expressed his thanks to Lorry Phelan who was stepping down as Staff Side Chair and welcomed Donato Tallo as the new Staff Side Chair.
8.8.	As part of the Chief Executive's report, Prof. Orchard noted the media coverage in respect of the Post Office and the issues arising from their Horizon IT system, and concerns received by the CQC in respect of the Trust Chair and whether she was a Fit and Proper Person. The Trust had examined the Trust's processes for compliance with the Fit and Proper Persons Regulations and he confirmed that the Chair has been open about the matter with NHS Improvement and with the Trust at the time of appointment and since. He confirmed that the Trust had benefitted from the Chair's expertise and her demonstration of the Trust values had helped build strong relationships. He confirmed that the Chair continued to have the

	confidence of NHS Improvement and the Trust and there are no new issues in respect of the Trust's compliance with the FPPR.
8.9.	In terms of the Coronavirus, Prof. Orchard confirmed that currently no cases of the virus had been confirmed in the UK to date and in the event of confirmed cases, the Trust had a plan for isolation and the advice from Public Health England was for people returning from China to self-quarantine for 14 days.
8.10.	The Board noted the report from the Chief Executive.
9.	Bi-monthly Integrated Quality and Performance report
9.1.	The Board noted the key headlines relating to performance as at November 2019. Prof. Redhead informed the Board that the Quality Committee had discussed the report at its meeting earlier in the month. He drew the Board's attention to the Hospital Standardised Mortality Ratio (HSMR) score ratio which was 72.0 in August 2019 and remains low, with the Trust ranked as the lowest (best) of acute non-specialist providers for Standardised Hospital Mortality Indicator (SHMI) score.
9.2.	Prof. Redhead highlighted that there had been 70 cases of hospital associated C. Difficile so far in the current financial year, above the trajectory of 37. However only one case had been related to a lapse in care. 18 of the 70 cases were community onset-hospital associated cases. He explained that there had generally been a rise in numbers across North West London with no explanation to date and not relating to a lapse in care or change in antibiotics and further work was ongoing across London to determine a cause.
9.3.	Prof. Redhead informed the Board that in November 2019, 90.5% of patients received antibiotics within one hour of their confirmed sepsis diagnosis, above the target of 90%. Work to implement the Sepsis alert in paediatrics and maternity services commenced in January 2020.
9.4.	Prof. Redhead reported one never event declared in January 2020 under the category 'misplaced naso or oro-gastric tube' and an investigation underway. Initial reviews indicate human error and not a failure in policy.
9.5.	Prof. Teoh informed the Board that in November and December 2019, the diagnostic target had not been met with a 175% increase in ultrasounds as the seasonable variation had increased. He was working with the CCGs to address this and he would report back to Board on discussions. Action: Prof. Teoh
9.6.	Responding to Mr Goldsbrough's comment regarding the drift in the vacancy rate, Mr Croft advised that the drift was in the right direction for the Trust and that he and Prof. Sigsworth had been working on the vacancy rate with various recruitment campaigns underway, which was having a positive impact. He also advised that work was progressing to retain staff.
9.7.	The Board noted the report.
10.	No decision items.
11.	Finance report
11.1.	The Board noted the financial position for the Trust as at 31 st December 2019.
11.2.	Ms Thind summarised the report: the actual year to date deficit was £14.45m (on plan); additional income associated with over performance in activity, mainly in relation to emergency work offset by the additional costs of delivery; in-month forecast improved by £3m bringing the overall gap to the control total to £4.5m mainly driven by an improvement in the Surgery, Critical Care and Cancer division forecast after a worsening in their position at month 8; the Trust continues to forecast to meet the control total; closing the financial gap to control

	total was likely to continue to require further non-recurrent actions/mitigations (one-offs) to be taken, resulting in a significant cost pressure being carried forward into 2020/21.
11.3.	The Board noted that the Provider Sustainability Fund regime would change for the next financial year and a plan was being developed.
11.4.	The report further outlined the requirements for the forecast position and the key risks or areas of concern impacting delivery of the control total.
11.5.	Dr Raffel commented that the challenges continue impacting the control total and continue to be discussed and challenged at the Finance, Investment and Operations Committee (FIOC). Ms Vennells added that hitting the control total was important but also needed to be done in a sustainable way which would be discussed further at the forthcoming Board away day.
11.6.	The Board noted the report.
12.	CQC update
12.1.	The Board noted the progress report which covered concerns, complaints and whistleblowing raised with the CQC; death reviews; CQC insight report; national reviews and surveys; an update on engagement meetings; and preparations for the upcoming CQC inspections.
12.2.	Mr Goldsbrough enquired about the confidence level that the inspections would move the Trust from its combined rating of 'good'. Prof. Orchard advised that it was not known at this stage which services the CQC would inspect, however if they selected some of the smaller services then it was unlikely that these would affect the overall rating for the Trust. He reported on the internal approach and initiatives underway to prepare services and staff.
12.3.	The Board noted the report.
13.	HMRC Business risk review
13.1.	The Board noted that the HM Revenue and Customs (HMRC) were due to visit the Trust in February 2020 in order to carry out a review of the Trust's arrangements for managing and disclosing its compliance with the UK tax regime. The Board noted that the HMRC's business risk review was a new risk based approach and the Trust was one of the first NHS organisations to go through the process therefore limited intelligence in terms of expectations. The report outlined the work carried out to date, policies and engagement with specialist to prepare for the visit.
13.2.	The Board noted the report, approved the Tax Strategy and noted the Tax Policy.
14.	Freedom to speak up (FTSU) 2020 plan
14.1.	The Board noted the background to the establishment of the FTSU initiative and the Trust's position thus far noting some of the difficulties in releasing time for the FTSU guardians. The Board welcomed Nat Johnson, FTSU Guardian, to the meeting.
14.2.	Mr Ross explained that following the completion of a self-assessment of compliance with the FTSU best practice, presented to the Board in March 2019, the Trust agreed a revised approach for speaking up, including moving the service to being part of the CEO's office and investment in additional resource and capacity to enable the FTSU guardians to carry out the full range of the role. The assessment also identified the need for increased awareness across the organisation regarding the role of the guardians and the support available to staff, therefore the Trust had developed its FTSU strategy focused on raising awareness, supporting those who raise concerns and improved reporting and coordination with other directorates so that themes could be identified and issues addressed.
14.3.	Mr Ross and Mr Jenkinson thanked Ms Nat Johnson, Lead FTSU Guardian, for the increased activity and her work since being appointed as the Lead Guardian.

14.4.	Mr Goldsbrough commended the work and stated it was an excellent initiative and welcomed the time and effort offered by the guardians and commented that it was everyone's job to be transparent and demonstrate the Trust values.
14.5.	Building on the values and behaviours work last year, Ms Vennells enquired about plans to continue the work. Mr Croft informed the Board that the work continues including value workshops, values ambassadors and other mechanisms and added that a report was recently submitted to the Executive People and Organisation Development Committee informing of progress.
14.6.	Ms Boycott suggested a joined up matrix capturing employee experience such as concerns arising from staff survey, and concerns raised via other sources including FTSU. Other Non-executive Directors agreed and suggested including excellence awards and staff stories to Board in the employee experience piece. Mr Croft would give some thought to this. Action: Mr Croft
14.7.	Prof. Orchard added that a significant amount of work has been done with general managers in terms of upskilling, values and behaviours which all staff must role model.
14.8.	Mr Ross made the point about fast tracking issues when raised and not prolonging actions and outcomes.
14.9.	The Board noted the priorities for 2020 in order to deliver the FTSU vision.
15.	Learning from deaths report
15.1.	The Board noted the progress with implementing the actions and recommendations to improve the Trust's learning from deaths processes; and noted the findings from the Trust's mortality surveillance programme in relation to Quarters 1 and 2 of 2019/20.
15.2.	The Board noted the report.
16.	Mid-year update on safe, sustainable and productive nursing and midwifery staffing
16.1.	The Board noted that the mid-year establishment review undertaken in November 2019 showed an increase of 40.29 WTEs in the establishment compared with data from the previous review in March 2019.
16.2.	The Board noted that the Trust has developed a set of schemes to help mitigate the impact of the skills shortages which included a range of actions to develop its nursing workforce including the introduction of the Nursing Associate role, apprenticeships in nursing and overseas recruitment and importantly focus on retaining nurses.
16.3.	Prof. Sigsworth added that the Nursing Directorate's Charity funded NIHR nurse undertook some research looking at impact when ward level changes and the results included that staff perception of safety changes which was an interesting element which Prog. Sigsworth and her team would look into.
16.4.	The Board noted the report.
17.	Pathway to excellence
17.1.	Prog. Sigsworth was pleased to report that the Trust had been selected as one of the 14 Trusts in England to participate in the Pathway to Excellence programme which focuses on promoting nursing and midwifery (N&M) excellence seeking to create a positive practice environment for staff which improves satisfaction and retention. The programme was closely aligned to the Trust's values and behaviours and will support the establishment of a leadership model focusing on continuous improvement.

17.2.	Ms Vennells congratulated the directorate on its successful selection. She noted that there appeared to be 14 'points of magnetism' for this programme and wondered whether the set up may become too bureaucratic for the N&M staff. Prof. Sigsworth acknowledged the size and scale of the programme but in essence it was a positive approach and welcomed by the N&M staff and they would work through the programme.
17.3.	Sir Gerald Acher also congratulated the directorate and suggested this is brought to the attention of North West London colleagues and included in a communications exercise/bulletin.
17.4.	The Board noted the report. Action: Ms Dixon
18.	Trust Board Committees – summary reports
18.1.	Audit Risk and Governance Committee
18.1.1.	The Board noted the summary points from the meeting held on 4 th December 2019, particularly noting that the auditors were concerned with year-end preparations due to the changes in the finance management team and loss of organisational knowledge.
18.2.	Quality Committee
18.2.1.	The Board noted the summary points from the meeting held on 15 th January 2020 particularly noting that a deep dive would be conducted into pressure ulcers lead by Prof. Sigsworth. A report would be presented to the Executive Quality Committee and the Board Quality Committee.
18.3.	Finance, Investment and Operations Committee
18.3.1.	The Board noted the summary points from the meeting held on 22 nd January 2020.
19.	Any other business There was no other business.
20.	Questions from the public
20.1.	A member of the public enquired about the command centre and whether the Trust was recording the 4 hour A&E performance metric as a real time. Prof. Orchard advised that NHSE have asked Trusts not to record the 4 hour metric but are recording real time data as part of the pilot of the proposed new urgent and emergency care metrics such as arrival time, time in department, time to assessment, time in the department and people are treated for critical illnesses as always. He added that there are positives and negatives to the old 4 hour standard which NHSE would include in their assessment.
20.2.	On the same point, another member of the public enquired whether the data would be available to the public. Prof. Orchard advised that when NHSE have field tested the proposed metrics and reviewed the results, they would release as much data as possible. At the moment the Trusts in the field test are unable to see comparative data amongst themselves.
20.3.	A member of the public enquired about the relationship between Trusts and PCNs and whether the new set up would mean that patients would elect not to go to Charing Cross Hospital. Prof. Orchard advised that the new set up would not change anything for patients in terms of where they are treated and their right to choose a provider. He explained that PCNs are trying to avoid people moving out of the area for treatment and making the services offered in their areas as attractive as possible.
21.	Date of next meeting 25 th March 2020, 10am, W12 Hammersmith Hospital

Updated: 18 March 2020

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meetings held on 29 January and 25/26 February 2020	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information/noting
Date of Meeting: 25 March 2020	Item 5, report no. 02
Responsible Executive Director: Professor Tim Orchard, chief executive officer	Author: Peter Jenkinson, Director of corporate governance
<p>Summary: Decisions taken, and key briefings, during the confidential sessions of a Trust board are reported (where appropriate) at the next Trust board meeting held in public. Items that are commercially sensitive are not published.</p> <p>January 2020 The Board received a report from the Chief Executive in which he updated the meeting on the Trust's participation in the field testing of the proposed new urgent and emergency care standards; and the reporting of the waiting time data for the new measures.</p> <p>The Board received a report setting out the Trust requirements, as a regulated provider under the Fit & Proper Persons Requirements (Directors) – NHS bodies, and the NHS Improvement (NHSI) and Trust processes in place around Executive and Non-executive appointments to ensure the Trust remained compliant with the regulatory requirements. The Board considered a recommendation to the Board that in respect of the appointment of the Chair, in current circumstances, the Trust remained compliant with Regulation 5 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The Board agreed the recommendation of the Chief Executive regarding the Trust's continued compliance with the Fit and Proper Persons Regulations.</p> <p>The Board received an update on commercial discussions to date, including ongoing discussions regarding the Trust's redevelopment programme.</p> <p>The Board considered a proposal to bring the management of hotel services in-house from April 2020, noting the context for such a proposal and noting actions taken following discussion at the last Trust Board meeting. The Board supported the approach to allow the existing hotel services contract to expire at the end of March 2020 and bring all contracted service staff and services in-house on an initial 24 month basis with a phased move to AfC terms and conditions. It was agreed to evaluate in six months' time from the start of the change therefore September Board.</p> <p>February 2020 The Board met in seminar mode over 25 and 26 February 2020 to understand the wider external context (strategic, regulatory, financial, operational, relational) in which the Trust strategic goals sit; consider and develop collective thinking on Trust priorities for 2020/21 that contribute to the delivery of agreed strategic goals and objectives; review the interim outputs from the business planning process for 2020/21; and develop the Trust's approach as a Board to ongoing strategy development and delivery. The highlights from this seminar are provided at item 8.</p>	
Recommendations: The Trust board is asked to note this report.	

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 29 January 2020

Updated: 18 March 2020

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	27 November 2019 9	Strategic development – Implementation of a management system (The Imperial Way)	<p>November 2019: Claire Hook highlighted that the proposed approach to delivering the Trusts strategy in a standardised way, linking in with the Trusts values and behaviours. Board members discussed the programme and agreed whilst they all supported the proposal, that there needed to be a clear and practical way of delivering it, with it being collectively owned by the executive team. The Board approved the Imperial management system (working title ‘the Imperial Way’) and noted the process for agreeing priorities for 2020/21 and the process for delivery of the 2019/20 objectives. An update outlining the delivery process and risks would be presented to a future board meeting.</p> <p>March 2020 update: Main agenda item (business planning)</p>	Tim Orchard/Claire Hook	March 2020
2.	29 January 2020 8.7.2	Staff Survey	<p>The results of the staff survey would be presented to the March 2020 meeting.</p> <p>March 2020 update: Main agenda item</p>	Kevin Croft	March 2020
3.	29 January 2020 9.5	Integrated Quality and Performance Report – Diagnostics	<p>Prof. Teoh informed the Board that in November and December 2019, the diagnostic target had not been met with a 175% increase in ultrasounds as the seasonable variation had increased. He was working with the CCGs to address this and he would report back to Board on discussions.</p> <p>March 2020 update: Oral update</p>	TG Teoh	March 2020
4.	29 January 2020 17.3	Pathway to excellence	<p>Sir Gerald Acher also congratulated the directorate and suggested this is brought to the attention of North West London colleagues and included in a communications exercise/bulletin.</p> <p>March 2020 update: Oral update</p>	Michelle Dixon	March 2020
5.	27 November 2019 13.6	Board Assurance Framework	<p>November 2019: Noting the changes to the Board Assurance Framework, Peter Goldsbrough asked whether the amount of time it would take to track assurance had been considered. Peter Jenkinson reflected that it shouldn’t take up much more time that it currently did but agreed to discuss this at the following Audit, Risk & Governance Committee and feedback. Discuss the time and resource required for the Board Assurance Framework at the Audit, Risk & Governance Committee on 4 March 2020, and feed back to board members at the Trust Board on 25 March 2020.</p> <p>January 2020 update: on the agenda for the March Audit, Risk & Governance Committee.</p> <p>March 2020 update: Discussed at ARG in March.</p>	Peter Jenkinson	May 2020

6.	29 January 2020 14.6	Employee metrics matrix (arising from FTSU item)	Ms Boycott suggested a joined up matrix capturing employee experience such as concerns arising from staff survey, and concerns raised via other sources including FTSU. Other Non-executive Directors agreed and suggested including excellence awards and staff stories to Board in the employee experience piece. Mr Croft would give some thought to this.	Kevin Croft	July 2020
7.	29 January 2020 7.3	Patient story review	January 2020: Prof. Sigsworth welcomed the comments and would discuss a plan with the Strategic Lay Forum, Executive Quality Committee and Quality Board Committee with a next steps plan to Board in summer.	Janice Sigsworth	July 2020

Items closed at the January 2020 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 September 2019 9.2	Board level governance	<p>The Board noted the deferment to Nicola Horlick taking up her appointment as non-executive director due to her being selected as a parliamentary candidate in the next general election, and agreed that this would be reviewed again in three months.</p> <p>January 2020 update: Nicola Horlick will not be resuming her role as Non-executive Director role at the Trust and recruitment will be underway to fill the vacancy.</p>	Paula Vennells/Peter Jenkinson	Closed
2.	27 November 2019 10.3	Bi-Monthly Integrated Quality and Performance Report	<p>Responding to a query from Kay Boycott and Paula Vennells regarding maternity sepsis, Prof Andy Bush confirmed that this had been discussed at the Quality Committee and no lapses in care had been identified. Prof Redhead would provide further assurance regarding maternity sepsis rates.</p> <p>January 2020 update: The sepsis rates were October 1%, November 1.3% and December 1% against the target of 1.5%. Therefore assurance provided that there is no issue of concern.</p>	Prof Redhead	Closed
3.	27 November 2019 22.3	Questions from the public	<p>The following actions were agreed as part of this discussion relating to the terms and conditions of Sodexo staff:</p> <ul style="list-style-type: none"> ▪ Weekly updates would continue to be shared by Kevin Croft with the union regarding discussions with Sodexo management. ▪ Prof Tim Orchard would confirm a timescale regarding the review into terms and conditions of Sodexo staff by the 3 December 2019. <p>January 2020 update: These actions have been completed.</p>	Prof Orchard/Kevin Croft	Closed

After the closed items have been to the proceeding meeting, then log these will be logged on a 'closed items' file on the shared drive.

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information
Date of Meeting: 25 th March 2020	Item 8, report no. 05
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	Author: Prof Tim Orchard, Chief Executive Officer
Summary: This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust. It will cover: <ol style="list-style-type: none"> 1) COVID-19 2) Operational performance 3) Financial performance 4) Transformation programme update 5) Imperial Management and Improvement System 6) Patient focus 7) Strategic development 8) People 9) Research and innovation 10) Stakeholder engagement 	
Recommendations: The Trust Board is asked to note this report.	
This report has been discussed at: N/A	
Quality impact: N/A	
Financial impact: The financial impact of this proposal as presented in the paper enclosed: N/A	
Risk impact and Board Assurance Framework (BAF) reference:	
Workforce impact (including training and education implications): N/A	
What impact will this have on the wider health economy, patients and the public? N/A	
Has an Equality Impact Assessment been carried out? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not applicable If yes, are there any further actions required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Paper respects the rights, values and commitments within the NHS Constitution. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Trust strategic goals supported by this paper: <ul style="list-style-type: none"> ▪ To help create a high quality integrated care system with the population of north west London 	

- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Chief Executive's Report to Trust Board

1. COVID19

We are currently caring for a number of patients who have tested positive for Coronavirus. All confirmed cases are being managed in line with Public Health England (PHE) guidance to minimise risk to other patients, visitors and staff. I am very grateful to all of our staff for the tremendous amount of work they have been doing, and will continue to do, to help contain the spread and to be fully prepared. Understandably some of our staff are concerned about Coronavirus and its impact and our focus will continue to be to best protect them as well as our patients and visitors at this very difficult time.

To respond to the rapidly changing situation nationally and regionally, we have implemented a "command and control" structure, much like how we would manage a major incident. Claire Hook, Director of Operational Performance, is the gold commander. We have also set up a number of workstreams, including people, operations, ward processes and equipment (including personal protection equipment) and communications. All staff are focused, or are being redeployed, on work to support essential business as usual and our response to Coronavirus. We are also enabling many more staff to be able to work from home, rolling our Microsoft Teams and other support.

We have restricted visiting arrangements. Whilst we know that it is important for our patients to see family and friends we are encouraging visitors to consider if their visit is essential and advising that patients can have only one visitor at a time, and no under 18s. Visiting times have been limited to 2-3pm every day.

In line with national guidance we have also restricted non-urgent activity to help us create additional capacity for emergency pathways especially critical care. Each consultant has reviewed their elective inpatient lists to identify patients who can be safely rescheduled. The majority of outpatient appointments have become 'virtual' – by telephone or video. We have also postponed all non-essential meetings and work that is not business critical.

The risk associated with disruption to business as usual has been escalated to the corporate risk register and will be reviewed weekly.

2. Operational Performance

Field testing of the proposed new Urgent and Emergency Care standards continues. Other operational performance will be covered in the IQPR.

3. Financial performance

Year to date, the Trust is on plan with a deficit of £8.8m before PSF which is being achieved through the use of significant non-recurrent mitigations. The Trust continues to focus on: reducing the run rate of spend, especially in relation to temporary staffing costs; and increasing the in-year delivery of cost improvement plans (CIPS) to ensure the organisation is best placed to deliver its 2020/21 financial plan. Current forecast delivery of CIP £43m.

Highlights:

- above plan on NHS clinical income activity, mainly due to non-elective, resulting in additional cost;
- additional activity has constrained the ability to deliver CIPs where these are linked to activity changes;
- reached agreement with both NWL commissioners and NHSE with regards to the level of income for 2019/20 providing greater certainty on the year-end position;
- out-turn at month 11 is forecast to be £4.4m worse than plan, a similar position to month 9; however we expect to recover this non-recurrently by the end of the financial year.

- There has been an £8.4m reduction in agency spend during the first 10 months of the year, of which £4.1m relates to reduction in A&C agency workers (down from 63 to 7); reflecting a 62% decrease in this staff group spend compared to same period last year. There has also been an overall reduction of £7.4m for all temporary staffing (bank and agency combined) year to date.

The finance report provides detail of the Trust's financial position for the eleven months to February 2020.

4. Transformation update

Since January 2020, and as part of the Business Planning process, Transformation have facilitated agreement to an agreed list of Focused Improvements, Projects and Programmes for 2020/21. These are a mix of operational improvement and strategic topics. Detailed plans are being worked up, ready for launch in Q1 2020/21. Business Planning presentations by Directorates have all been completed, and a prioritised 2020/21 budget, in line with the agreed Trust priorities, is in the process of being finalised by the Executive team.

Other initiatives include:

- Implementation of the Imperial Management & Information System is being worked up, with Transformation and QI aligning on the necessary internal training needed for roll-out.
- Transformation training and development for General Managers has been arranged, as part of the wider GM Development programme, albeit postponed due to COVID-19.
- Project management is being established, using Microsoft Teams, which will align and eventually standardise how the Trust structures all project activity.
- Transformation is also providing support to the Director of Operational Performance in the current response to COVID-19.

5. Imperial Management and Improvement System

A multi-disciplinary working group, led by the Director of Operational Performance, was established in December 2019 with the purpose of designing an implementation plan for the Imperial Management and Improvement System (IMIS).

The working group considered four deployment options. Each option was assessed against pre-agreed criteria, with the key consideration being a requirement to minimise the risk of double-running the "as-is" and "to-be" management frameworks. In recognition of the significant level of work required to develop and embed the performance scorecards necessary to make the IMIS a success, and after consideration of the cost profile of each implementation option, the working group recommended a focus on executive routines and scorecard cascade in year 1. This approach was approved by the Executive Operational Performance Committee in February and reviewed at the Finance, Investment and Operations Committee in March. This means that the Trust Board will receive performance data for March 2020 in both the existing IQPR format and in the proposed new IMIS format in May, with the hope that the new arrangements can be implemented in full for 2020/21 data.

6. Patient focus

Patient safety conference

Innovative thinking about patient safety and building a just working environment was at the heart of the Trust's first patient safety conference held on 24th February 2020.

Over 140 delegates took part in the conference which showcased the safety improvement work taking place across the Trust. Entitled 'From Strategy to the frontline', the conference featured leading national speakers on patient safety including Dr Aiden Fowler, the National Director of Patient Safety at NHS Improvement, and Dr Henrietta Hughes, the National Freedom to Speak Up Guardian for the NHS.

A centre-piece of the conference was a poster competition to promote innovative new ideas around patient safety. The winning poster by Catherine Sendall (Care home liaison role: bridging the role

between acute hospitals and care homes') united the competition's three themes – insight, involvement and improvement – in a single poster which delivered clear and varied outcomes of safety, experience and cost-saving.

7. Strategic development

Redevelopment

We have a formal agreement to enter into partnership discussions between the Trust and Great Western Developments Ltd, working with Sellar. The agreement allows joint work and engagement to take place over the next six months on how the developer could build a new St Mary's Hospital.

A new St Mary's Hospital, plus significant new developments and refurbishments at the Trust's Charing Cross and Hammersmith/Queen Charlotte's and Chelsea hospitals, is included in the Government's Health Infrastructure Plan. An initial £5 million was awarded to the Trust last month to help it produce detailed plans and business cases for the redevelopments. Additional Government funding will be sought to help complete the funding requirements for all of the developments.

The new St Mary's Hospital would be built on an area of the existing hospital site in Paddington, primarily in return for land that would then be surplus to requirements.

The discussions are starting with an outline timetable for planning and business case approvals for St Mary's to be completed by early 2022 and a new hospital built and fitted out by 2027. Significant improvements at Charing Cross and Hammersmith are currently scheduled to begin in 2022.

We are also working closely with Imperial Health Charity, who own part of the St Mary's land earmarked for wider development, as well as Imperial College London.

8. People

Hotel Services

Operational planning is well underway to prepare for 1000 Hotel Services staff to complete a TUPE transfer of employment into the Trust on 1 April 2020, with key workstreams including the preparation for paying staff, transfer of employment, and provision of training and induction.

Culture Programme

The culture programme is active with 100 Values and Behaviours Ambassadors now trained and helping to deliver values workshops, Active Bystander and other workshops across the Trust.

MBA and Masters in Leadership and Management

We have completed procurement for the introduction of an MBA and Masters in Leadership and Management using our Apprentice Levy funding, due for launch in Autumn 2020.

Nurse Recruitment and Retention Programme

The Nurse Recruitment and Retention programme continues to work on reducing the nursing vacancy rate. The Trust's vacancy rate has maintained below 10.0% since January 2020, currently at 9.7%. Nursing and Midwifery vacancies are now at 11.5% and continuing to meet the Trust target for this group.

Flu Campaign

This year, the final Trust flu campaign uptake figure is 69.2%. This is the highest annual uptake to date and is a marked improvement compared to last year's figure of 60%.

Doctor's Bank

A major new development in temporary staffing is the launch of the new Doctors Bank, facilitated by a dynamic app, 'Patchwork'. The Trust's bank rates for Doctors will move to be the same as the pan London capped rates, bringing us in line with the rest of NWL STP. Imperial Private Health went live with the new Centralised Doctors Bank in January 2020, and in the first month saw a 97% overall fill rate.

Equality and Diversity

EDS2 is a set of nationally agreed goals and outcomes which provides participating Trusts with a systematic way of meeting the public sector equality duty under the Equality Act 2010. It comprises of eighteen outcomes over four goals within patient and workforce areas. Following a review of the evidence base, engagement with key stakeholders and approval from the Equality, Diversity and Inclusion (EDI) committee, grades and priorities for the Trust have been set under the EDS2 framework.

Based on the available data indicating areas of concern, and alignment with existing priorities under the EDI work programme, the below five outcomes, set under EDS2, will be prioritised for 2020-2023:

- Ensuring that BAME patients who do not speak English are able to access appropriate support so that they have a clear understanding of their treatments and options
- Transitions from one service to another for people on care pathways, are made smoothly with everyone informed - protected characteristic being considered
- Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- When at work, staff are free from abuse, harassment, bullying and violence from any source.

A summary is published on the Trust website, and the grading and priorities will be reviewed on a 3-yearly basis.

We now have two new staff networks established, the 'I CAN' network for staff with disabilities and a Trust Wide network for Black, Asian and Minority Ethnic (BAME) staff to build on the success of the Nursing and Midwifery BAME network. Additionally we now have Executive sponsors for each of the networks (listed below).

- Nursing and Midwifery BAME network - Janice Sigsworth
- Trust BAME network - Julian Redhead
- I CAN network - Katie Urch and Peter Jenkinson
- Women's network - Michelle Dixon and Jazz Thind
- LGBT+ network - Jeremy Butler and Frances Bowen

Unfortunately, the Leadership Forum planned for 31 March 2020, that was going to focus on equality, diversity and inclusion and the formal launch of the Trust Wide BAME network on the same, has had to be postponed due to COVID-19.

9. Research and innovation**Research**

In light of the COVID-19 pandemic, in conjunction with colleagues within Imperial College and based on national advice, we have made the decision to suspend all clinical research trials as our default position. We have set up an exemption process where Principal Investigators (PIs) can apply to a clinical and academic panel to be granted exemptions on a trial-by-trial basis. We have agreed to review this process on a weekly basis to ensure the balance of risks are optimised.

Strategic planning work continues in preparation for our re-application to be a Biomedical Research Centre (BRC) and also for our re-application for hosting our regional Clinical Research Network (CRN), both of which are expected to open as application processes later in 2020.

AHSC Re-designation

We were interviewed at the end of February (2020) to be considered for Academic Health Science Centre (AHSC) re-designation. We envisage that we will hear the outcome of this process within the next few weeks. The aim of the newly designated AHSCs is to harness the strategic alignment of NHS organisations and their university partners to improve health and care through increased translation of discoveries from early scientific research into benefits to patients.

10. Stakeholder engagement

Below is a summary of significant meetings and communications with key stakeholders since the last Trust Board meeting:

- Strategic Lay Forum: 6 February
- Edward Argar MP, Minister of State for Health: 6 February
- Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith & Fulham: 7 February
- Healthwatch Central West London: 10 February
- Hammersmith & Fulham Save our NHS: 21 February
- Cllr Iain Bott, Westminster City Council: 25 February
- Cllr Tim Mitchell, Westminster City Council: 27 February
- Felicity Buchan MP and Rt Hon Greg Hands MP: 6 March
- Stuart Love, Westminster City Council: 10 March
- Cllr Robert Freeman, Royal Borough of Kensington and Chelsea: 16 March
- Karen Buck MP and Andy Slaughter MP: 17 March

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Business planning 2020/21 – Trust priorities	<input type="checkbox"/> Approval <input checked="" type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input type="checkbox"/> Information
Date of Meeting: 25 th March 2020	Item 8, report no. 05
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	Author: Peter Jenkinson, Director of corporate governance Bob Klaber, Director of strategy, research and innovation Jazz Thind, Chief financial officer
<p>Summary:</p> <p>The purpose of this paper is to present to the Board a summary of the proposed priorities for the Trust for 2020/21, as discussed in the February 2020 Board strategy seminar, and to present the impact of the Trust's response to the current Covid-19 pandemic on these priorities.</p> <p>The Trust introduced a revised business planning process in the Trust for 2020/21, under the leadership of the Director of Transformation, as part of the implementation of the Imperial Way (as presented to the Board previously).</p> <p>That process produced priorities for 2020/21, agreed by the Trust executive, in the form of programmes, projects and focused improvements. These priorities will support the delivery of the Trust's strategic goals as previously agreed.</p> <p>As the Trust responds to the current COVID-19 pandemic, the Trust is needing to adapt focus and prioritisation on a daily basis, but in the background to this a number of key priority projects and programmes are continuing to run, albeit with a different focus and in some cases at a reduced scale.</p> <p>Appendix 1 summarises the latest thinking on the evolution of our priorities in order to meet the Covid-19 pandemic.</p>	
<p>Recommendations:</p> <p>The Trust Board is asked to note this report and note the Trust priorities for 2020/21.</p>	
This report has been discussed at: N/A	
Quality impact: N/A	
<p>Financial impact:</p> <p>The financial impact of this proposal as presented in the paper enclosed: N/A</p>	
Risk impact and Board Assurance Framework (BAF) reference:	
Workforce impact (including training and education implications): N/A	
What impact will this have on the wider health economy, patients and the public? N/A	

Has an Equality Impact Assessment been carried out?

Yes No Not applicable

If yes, are there any further actions required? Yes No

Paper respects the rights, values and commitments within the NHS Constitution.

Yes No

Trust strategic goals supported by this paper:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Business planning 2020/21**1. Purpose**

The purpose of this paper is to present to the Board a summary of the proposed priorities for the Trust for 2020/21, as discussed in the February 2020 Board strategy seminar, and to present the impact of the Trust's response to the current Covid-19 pandemic on these priorities.

2. Background

The Trust introduced a revised business planning process in the Trust for 2020/21, under the leadership of the Director of Transformation, as part of the implementation of the Imperial Way (as presented to the Board previously).

That process produced priorities for 2020/21, agreed by the Trust executive, in the form of programmes, projects and focused improvements. These priorities will support the delivery of the Trust's strategic goals as previously agreed:

**3. Priorities for 2020/21**

The outputs of the business planning process, in terms of priorities for 2020/21, were presented to the Board at a strategy seminar session in February 2020.

The purpose of the seminar was to:

- Understand the wider external context (strategic, regulatory, financial, operational, relational) in which our strategic goals sit
- Consider and develop our collective thinking on our priorities for 20/21 that contribute to the delivery of our agreed strategic goals and objectives
- Review the interim outputs from the business planning process for 2020/21
- Develop our approach as a Board to ongoing strategy development and delivery

The seminar consisted of various sessions, including:

- **Implementing our strategy** – focusing on the methodology and processes used to get us to where we are now. The session also included a review of the internal and external context – the regulatory landscape and the challenges faced by NW London sector and the impact on the Trust.
- **Quality improvement – the national picture** – Hugh McCaughey, NHS Improvement Director of improvement, discussed with the Board the development of the national improvement framework and the role of NHS boards in strategy development, deployment and improvement.
- **Draft financial plan 2020/21** – focusing on draft outputs from the business planning process in terms of the draft outline financial plan and key risks emerging from the planning round.
- **Board governance – the role of Board committees** – focusing on the role of the Board committees in their role of ‘steering’ (developing strategy) and ‘oversight’ (delivery of strategy). This work will continue in reviewing the effectiveness of committees and their respective work plans.
- **Projects & Programmes 2020/21** – focusing on the key programmes of work for 2020/21.

The agreed priorities for 2020/21, are summarised in the table below:

<p>Focused improvements – 3-5 recognisable metrics that the majority of the organisation can contribute to</p>	<p>Improve FFT Response Rate* Improving the quality of feedback provided in the FFT responses to feed the natural language processing tool to better understand the positive and negative experiences of patients.</p> <p>Improve % of staff who feel they are able to make improvements in their area Targeting support at low response areas to understand their top contributing reasons why they feel they are unable to make improvements in their area and supporting improved engagement and capabilities in improvement initiatives.</p> <p>Improve incident reporting rate Improving incident reporting rates to bring focus to safety and quality priorities, and to the Trust’s values and behaviours framework, to create a patient-centred culture.</p> <p>Reduce temporary staffing spend Creating a safe and sustainable workforce by focusing on the top areas with high temporary staffing spend, understanding their root causes</p>
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	and supporting them through our Safe and Sustainable Staffing workstreams. Reduce number of patients with a length of stay of 21 days or more Improving our bed occupancy performance, and therefore timely access for patients requiring a bed, by reducing the number of medically fit patients with a length of staff of 21 days or more.
Programmes – ‘Must do, can’t fail’ that will have a significant impact on strategic goals	Step change programmes: <ul style="list-style-type: none"> • Redevelopment • Culture • ICHT & C&WFT Collaboration • Imperial Way / Management & Improvement System • West London Children’s Initiative • Safe & Sustainable Staffing • Outpatients Transformation Important programmes: <ul style="list-style-type: none"> • Access, Data Quality Improvement • Pathway to Excellence • Care Journey Capacity Collaborative (CJCC) To be scoped during FY20/21: <ul style="list-style-type: none"> • Sustainability Development Management Plan • Anchor Institute
Projects – task and finish complex or corporate projects that need to be delivered this year	<ul style="list-style-type: none"> • Soft FM Provision • Critical Care Hammersmith Hospital development • HOTT Programme • Medical Examiner Service • CQC Preparation • Command Centre • SIAM OBC development • Use of Apprenticeship levy • PCN ‘Test Bed’ • Nursing Care Plans

4. Trust response to Coronavirus pandemic – revision to Trust priorities

By the end of February 2020 it had become increasingly clear that the Covid-19 epidemic that had led to multiple deaths and whole cities and countries being locked down in China and the Far East, was likely to hit many countries’ healthcare systems in a pandemic of unprecedented scale. Since then the Trust, at every level of the organisation, has been fully focused on mounting a comprehensive approach to this extraordinary challenge. The foundations that we have been building around the organisational culture, values and behaviours and the early development of a consistent operating model are proving to be essential in our response.

As the scale of this pandemic unfolds we are needing to adapt our focus and prioritisation on a daily basis, but in the background to this a number of key priority projects and programmes are continuing to run, albeit with a different focus and in some cases at a reduced scale.

Appendix 1 summarises the latest thinking on the evolution of our priorities in order to meet the Covid-19 pandemic. Our expectation is that we will continue to need to review this on a regular basis and will keep the Board updated on any changes to this.

Key points: Step change projects and programmes focused on redevelopment & the soft FM provision are continuing, albeit with some changes (eg around exploring ways to engage with staff and patients on redevelopment through digital means in place of face to face gatherings)

- Step change projects and programmes around culture (including new ways of working), stock control, medical examiner, quality & safety, safe & sustainable staffing, OP transformation and the Imperial Way management & improvement system are key tenets of our Covid-19 response. The programmes have had to adapt and in many cases be rapidly fast-tracked. Others, such as the HOTT programme, have had to adapt; in this example focusing now on simulation and training around intensive care competencies, but continuing to have that emphasis on quality and safety of care
- Some important programmes are continuing but adapting to the Covid-19 response; an example of this would be the Care Journey & Capacity Collaborative which is helping support key emergency pathways in our hospitals
- A number of projects and programmes have been put on 'pause', as highlighted in Appendix 1
- Our focused improvement work is currently paused, although work around long stay patients is an important part of our Covid-19 work to free up hospital beds for new admissions and we are putting a specific safety emphasis on improving and maintaining high standards of hand hygiene as we know this is a crucial tenet of our Covid-19 response.
- It is hoped that we will still be able to scope the anchor institute work, and in particular how that supports our redevelopment work, but that is likely to happen later on in the year depending on how the Covid-19 situation develops.

5. Financial planning

5.1 2020/21 financial planning assumptions pre COVID-19

The outputs of the financial planning process set out the following headlines:-

- Income and expenditure bridge
- Efficiency Gap
- Cost improvement plans
- Opportunities to close the 'unidentified' gap
- Current capital plan
- Decision to accept or not the notified trajectory

In June 2019 NHSE/I launched its Long Term Plan for the NHS, followed by the publication of the Detailed Planning Guidance in February 2020. Key headlines included:

- Focus on system working
- 50% of the organisational FRF linked to 'system achieving system control total'
- MRET funding linked to agreement of trajectory
- Extra national income available for those breaking even or in surplus.
- Revenue transformation funding; dependant on agreement of system plans with NHSE/I
- Conversion of historic working capital loans to Public Dividend Capital
- MHIS and community / primary care investment commitment intact
- Releasing Time for Care – new national programme launched to support delivery of system efficiency

- A number of operational 'asks' e.g. 92% bed occupancy; patient choice at 26 weeks etc.

In building its financial plan the Trust considered a number of key factors drawn from either national guidance or local internal/external discussions which resulted in an efficiency challenge of £66.2m (6.8% of cost base) to deliver the notified 20/21 trajectory. Contracted income for both local NWL CCGs and NHSE was assumed to be landed at the values calculated by the Trust with QIPP excluded until such time robust, clinically approved schemes are signed off by clinical colleagues.

On the basis that the Trust had not fully closed its efficiency gap the Board agreed the 5th March submission would signal the Trust was not able to accept its trajectory but would continue to review opportunities to close the remaining gap by the next plan submission on 29th April.

5.2 2020/21 financial planning assumptions post COVID-19

The attached letter (Appendix 2) sent by Sir Simon Stevens (NHS CEO) and Amanda Pritchard (NHS COO) sets out the key 'asks' of the NHS community to ensure staff and other resources are redirected to the management of COVID-19.

Operational planning for 2020/21 is therefore suspended pending further notice.

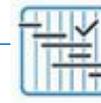
Commissioners are asked to agree block contracts with their NHS providers for the period 1st April to 31st July 2020 providing a guaranteed monthly payment. The below sets out some key headlines for the 4 month period to 31st July 2020:-

- block sum to be calculated nationally
- this will be based on the average monthly spend implied in the month 9 (December 2019) submission
- will include an uplift that allows for inflation and CNST
- will exclude the tariff efficiency factor
- will not include activity growth
- no longer require charging of non-contracted activity where applicable with a sum equivalent to the historical monthly average added to the provider's co-ordinating commissioner block contract
- will offer a national top-up payment will be provided to providers where the expected cost base (average monthly spend between November 2019 and January 2020 uplifted for inflation) is greater than the income guaranteed on the basis of the above. Providers to be notified of values on 23rd March 2020
- will allow providers to be able to claim for genuine and reasonable additional marginal costs due to COVID -19, with all commitments underpinned by robust financial governance.
- claims for top-up funding is to be made on a monthly basis, alongside regular monthly financial reporting resulting in providers delivering a break-even position throughout the initial four month period. This will provide the basis against which NHSE/I will monitor financial performance.
- block contract payments should not be revised to reflect an shortfall in normal contractual performance
- any contract sanctions in place will be suspended
- cash is required to flow in a timely manner ensuring the need for working capital is minimised

Irrespective of COVID-19 the Finance function will continue to review and update its financial plan internally to reflect the updated funding considerations set out in the letter. This process will then allow draft budgets to be set so that the Trust can monitor its financial performance in the usual manner. The plan will be built using:

- 'Next steps on NHS response to COVID-19' for April to July 2020
- previous assumptions for August to March 2021

Programmes and Projects Prioritisation (February 2020)



Category

Programmes

Projects

Category	Programmes	Projects
Requires more info	<ul style="list-style-type: none"> Quality safety improvement programme 	<ul style="list-style-type: none"> Stock control and GSI scan for safety Wayfinding Coding Improvement Project
To be scoped during 20/21	<ul style="list-style-type: none"> Sustainability Development Management Plan Programme Anchor Institute 	
Step Change	<ul style="list-style-type: none"> Redevelopment (inc. J block) CW/ICHT collaboration <ul style="list-style-type: none"> Clinical services Back office Governance West London Children's initiative Imperial Way Delivery System 	<ul style="list-style-type: none"> OP transformation (including CIE) Safe and Sustainable Staffing Programme Culture programme: (Collaborative Working (O365), user focus/brand, value & behaviours, active bystander)
Important (direct, high impact but optional)	<ul style="list-style-type: none"> Access, DQ improvement programme CJCC 'mean time in ED' Pathway To Excellence 	<ul style="list-style-type: none"> SIAM OBC development Nursing care plans Command Centre project Use of apprenticeship levy PCN 'Test Bed'
Local / BAU	<ul style="list-style-type: none"> IPH £55-57m => £60m SRP (internal e.g Vascular) Surgical Pathway Improvement Programme 	<ul style="list-style-type: none"> MTC resilience / TTL rota Commercial Corporate cancer sustainability funding BRC & CRN re accreditation MES cath lab

Programmes and Projects Prioritisation (March 2020)

Category	Programmes	Projects
Requires more info		<ul style="list-style-type: none"> Wayfinding Coding Improvement Project
To be scoped during 20/21	<ul style="list-style-type: none"> Sustainability Development Management Plan Programme Anchor Institute 	
Step Change	<ul style="list-style-type: none"> Redevelopment (inc. J block) OP transformation (including CIE) Imperial Way Management & Improvement System Safe and Sustainable Staffing Programme Culture programme: (Collaborative Working (O365), user focus/brand, value & behaviours, active bystander) Quality safety improvement programme 	<ul style="list-style-type: none"> CC HH development Medical Examiner Service Soft FM Provision Stock control and GSI scan for safety
Important (direct, high impact but optional)	<ul style="list-style-type: none"> Access, DQ improvement programme CJCC (in response to COVID) 	<ul style="list-style-type: none"> SIAM OBC development Nursing care plans Command Centre project
Local / BAU	<ul style="list-style-type: none"> IPH £55-57m => £60m SRP (internal e.g Vascular) Surgical Pathway Improvement Programme 	<ul style="list-style-type: none"> MTC resilience / TTL rota Commercial Corporate cancer sustainability funding BRC & CRN re accreditation MES cath lab
On Pause	<ul style="list-style-type: none"> CW/ICHT collaboration West London Children's initiative Pathway To Excellence 	<ul style="list-style-type: none"> PCN 'Test Bed' Use of apprenticeship HOTT Programme Preparing for CQC levy

Prioritisation changes in response to COVID for FY20/21

Category	February 2020		March 2020	
	Step Change	Important	Step Change	Important
Programmes	7	3	6*	2*
Projects	5	5	4	3

* 7 out of 8 Trust Programmes have had their key actions for FY20/21 realigned to support the Trust's COVID-19 response. The only Trust Programme that will deliver, where possible, milestones against the original plan for the next financial year is the Redevelopment programme.



To:

Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services

NHS England and NHS Improvement
80 London Road
Skipton House
London SE1 6LH
england.spc@nhs.net

Copy to:

Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums
Chairs of ICSs and STPs
NHS Regional Directors
NHS 111 providers

17 March 2020

Dear Colleague,

IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19

Thank you for your extensive work to date to prepare for this rapidly increasing pandemic, following the NHS declaration of a Level 4 National Incident on 30 January.

Last night the Government announced additional measures to seek to reduce the spread across the country. It is essential these measures succeed. However as the outbreak intensifies over the coming days and weeks, the evidence from other countries and the advice from SAGE and the Chief Medical Officer is that at the peak of the outbreak the NHS will still come under intense pressure.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to redirect staff and resources, building on multiple actions already in train. These will:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.

- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

Please therefore now enact the following measures:

1. Free-up the maximum possible inpatient and critical care capacity

The operational aim is to expand critical care capacity to the maximum; free up 30,000 (or more) of the English NHS's 100,000 general and acute beds from the actions identified in a) and b) below; and supplement them with all available additional capacity as per c) below. To that end, trusts are asked now to:

- a) Assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. However you also have full local discretion to wind down elective activity over the next 30 days as you see best, so as to free up staff for refresher training, beds for COVID patients, and theatres/recovery facilities for adaptation work. Emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. In the interim, providers should continue to use all available capacity for elective operations including the independent sector, before COVID constraints curtail such work. This could free up 12,000-15,000 hospital beds across England.
- b) Urgently discharge all hospital inpatients who are medically fit to leave. Community health providers must take immediate full responsibility for urgent discharge of all eligible patients identified by acute providers on a discharge list. For those needing social care, emergency legislation before Parliament this week will ensure that eligibility assessments do not delay discharge. New government funding for these discharge packages and to support the supply and resilience of out-of-hospital care more broadly is being made available. (See section 6f of this letter). Trusts and CCGs will need to work with local authority partners to ensure that additional capacity is appropriately commissioned. This could potentially free up to 15,000 acute beds currently occupied by patients awaiting discharge or with lengths of stay over 21 days.
- c) Nationally we are now in the process of block-buying capacity in independent hospitals. This should be completed within a fortnight. Their staff and facilities will then be flexibly available to you for urgent surgery, as well as for repurposing their beds, operating theatres and recovery facilities to provide respiratory support for COVID-19 patients. As soon as we have the detailed capacity map of what will be available in each part of the country we will share that with you via Regional Directors. NHS trusts and foundation trusts should

free up their own private pay beds where they exist. In addition, community health providers and social care providers are asked to free up community hospital and intermediate care beds that could be used flexibly within the next fortnight. These measures together could free up to 10,000 beds.

2. Prepare for, and respond to, large numbers of inpatients requiring respiratory support

Emerging international and UK data on COVID-19 patients suggests that a significant proportion who are hospitalised require respiratory support, particularly mechanical ventilation and to a lesser extent non-invasive ventilation.

- a) Work is well in hand nationally to secure a step change in oxygen supply and distribution to hospitals. Locally, hospital estates teams have now reported on their internal oxygen piping, pumping and bedside availability. All trusts able to enhance these capabilities across their estate are asked to do so immediately, and you will be fully reimbursed accordingly. The goal is to have as many beds, critical care bays, theatre and recovery areas able to administer oxygen as possible.
- b) National procurement for assisted respiratory support capacity, particularly mechanical ventilation, is also well under way in conjunction with the Department of Health and Social Care. In addition, the Government is working with the manufacturing sector to bring new manufacturers online. These devices will be made available to the NHS across England, Wales, Scotland and Northern Ireland according to need. Mark Brandreth, chief executive of Agnes Jones and Robert Hunt foundation trust is now supporting this work.
- c) In respect of PPE, the DHSC procurement team reports that nationally there is currently adequate national supply in line with PHE recommended usage, and the pandemic influenza stockpile has now been released to us. However locally distribution issues are being reported. Michael Wilson, chief executive of SASH, is now helping resolve this on behalf of the NHS. In addition if you experience problems there is now a dedicated line for you: 0800 915 9964 / 0191 283 6543 / Email: supplydisruptionsservice@nhsbsa.nhs.uk.
- d) A far wider range of staff than usual will be involved in directly supporting patients with respiratory needs. Refresher training for all clinical and patient-facing staff must therefore be provided within the next fortnight. A cross-specialty clinical group supported by the Royal Colleges is producing guidance to ensure learning from experience here and abroad is rapidly shared across the UK. This will include: a short education package for the entire NHS workforce; a service guide, including for anaesthetics and critical care; COVID-19 clinical management guides in collaboration with NICE.

- e) Segregate all patients with respiratory problems (including presumed COVID-19 patients). Segregation should initially be between those with respiratory illness and other cases. Then once test results are known, positive cases should be cohort-nursed in bays or wards.
- f) Mental Health, Learning Disability and Autism providers must plan for COVID-19 patients at all inpatient settings. You need to identify areas where COVID-19 patients requiring urgent admission could be most effectively isolated and cared for (for example single rooms, ensuite, or mental health wards on acute sites). Case by case reviews will be required where any patient is unable to follow advice on containment and isolation. Staff should undergo refresher training on physical health care, vital signs and the deteriorating patient, so they are clear about triggers for transfer to acute inpatient care if indicated.

3. Support our staff, and maximise staff availability

- a) The NHS will support staff to stay well and at work. Please ensure you have enhanced health and wellbeing support for our frontline staff at what is going to be a very difficult time.
- b) As extra coronavirus testing capability comes on line we are also asking Public Health England as a matter of urgency to establish NHS targeted staff testing for symptomatic staff who would otherwise need to self-isolate for 7 days. For those staff affected by PHE's 14 day household isolation policy, staff should - on an entirely voluntary basis - be offered the alternative option of staying in NHS-reimbursed hotel accommodation while they continue to work. Sarah-Jane Marsh, chief executive of Birmingham Women's and Children's foundation trust is now supporting this work.
- c) For staff members at increased risk according to PHE's guidance (including pregnant women), if necessary, NHS organisations should make adjustments to enable staff to stay well and at work wherever possible. Adjustments may include working remotely or moving to a lower risk area. Further guidance will be made available and the Royal College of Obstetrics and Gynaecology will provide further guidance about pregnant women.
- d) For otherwise healthy staff who are at higher risk of severe illness from COVID-19 required by PHE's guidance to work from home, please consider how they can support the provision of telephone-based or digital / video-based consultations and advice for outpatients, 111, and primary care. For non-clinical staff, please consider how they can continue to contribute remotely. Further guidance will be made available

- e) The GMC, NMC and other professional regulators are also writing to clinicians who have relinquished their licence to practice within the past three years to see whether they would be willing to return to help in some capacity.
- f) Urgent work is also underway led by chief nursing officer Ruth May, NHS chief people officer Prerana Issar and Health Education England, the relevant regulators and universities to deploy medical and nursing students, and clinical academics. They are finalising this scheme in the next week.
- g) All appropriate registered Nurses, Midwives and AHP's currently in non-patient facing roles will be asked to support direct clinical practice in the NHS in the next few weeks, following appropriate local induction and support. Clinically qualified staff at NHSE/I are now being redeployed to frontline clinical practice.
- h) The four UK chief medical officers, the national medical director, the Academy of Medical Royal Colleges and the GMC have written to all UK doctors stressing that it will be appropriate and necessary for clinicians to work beyond their usual disciplinary boundaries and specialisms under these difficult circumstances, and they will support individuals who do so. (see https://www.aomrc.org.uk/wp-content/uploads/2020/03/0320_letter_supporting_doctors_in_COVID-19.pdf) Equivalent considerations apply for nurses, AHPs and other registered health professionals.

4. Support the wider population measures newly announced by Government

Measures announced last night are detailed at:

<https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults>

- a) Ministry of Housing, Communities and Local Government (MHCLG) and local authorities in conjunction with their Local Resilience Forums (LRFs) have lead responsibility for overseeing support for older and vulnerable people who are going to be 'shielded' at home over the coming months. Community health services and voluntary organisations should engage with LRFs on how best to do this.
- b) A number of these individuals would be expected to have routine or urgent GP, diagnostic or outpatient appointments over the coming months. Providers should roll out remote consultations using video, telephone, email and text message services for this group as a priority and extend to cover all important routine activity as soon as possible, amongst others. David Probert, chief

executive of Moorfields foundation trust, is now leading a taskforce to support acute providers rapidly stand up these capabilities, with NHSX leading on primary care. Face-to-face appointments should only take place when absolutely necessary.

- c) For patients in the highest risk groups, the NHS will be identifying and contacting them over the coming week. They are likely to need enhanced support from their general practices, with whom they are by definition already in regular contact. GP services should agree locally which sites should manage essential face-to-face assessments. Further advice on this is being developed jointly with PHE and will be available this week.
- d) As part of the overall 'social distancing' strategy to protect staff and patients, the public should be asked to greatly limit visitors to patients, and to consider other ways of keeping in touch such as phone calls.

5. Stress-test your operational readiness

- a) All providers should check their business continuity plans and review the latest guidance and standard operating procedures (SOP), which can be found at www.england.nhs.uk/coronavirus/.
- b) Trust Incident Management Teams – which must now be in place in all organisations - should receive and cascade guidance and information, including CAS Alerts. It is critical that we have accurate response to data requests and daily sitrep data to track the spread of the virus and our collective response, so please ensure you have sufficient administrative capacity allocated to support these tasks.
- c) For urgent patient safety communications, primary care providers will be contacted through the Central Alerting System (CAS). Please register to receive CAS alerts directly from the MHRA:
<https://www.cas.mhra.gov.uk/Register.aspx>.
- d) This week we are undertaking a system-wide stress-testing exercise which you are asked to participate in. It takes the form of a series of short sessions spread over four days from today. Each day will represent a consecutive week in the response to the outbreak, starting at 'week six' into the modelled epidemic. We would strongly encourage all Hospital Incident Management Teams with wider system engagement (including with primary care and local government representation) to take part.

6. Remove routine burdens

To free you up to devote maximum operational effort to COVID readiness and response, we are now taking the following steps nationally:

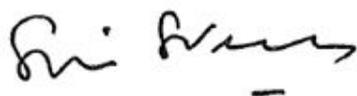
- a) Cancelling all routine CQC inspections, effective immediately.
- b) Working with Government to ensure that the emergency legislation being introduced in Parliament this week provides us with wide staffing and regulatory flexibility as it pertains to the health and social care sector.
- c) Reviewing and where appropriate temporarily suspending certain requirements on GP practices and community pharmacists. Income will be protected if other routine contracted work has to be substituted. We will issue guidance on this, which will also cover other parts of the NHS.
- d) Deferring publication of the NHS People Plan and the Clinical Review of Standards recommendations to later this year. Deferring publication of the NHS Long Term Plan Implementation Framework to the Autumn, and recommending you do the same for your local plans.
- e) Moving to block contract payments 'on account' for all NHS trusts and foundation trusts for an initial period of 1 April to 31 July 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes.
- f) Additional funding to cover your extra costs of responding to the coronavirus emergency. Specific financial guidance on how to estimate, report against, and be reimbursed for these costs is being issued this week. The Chancellor of the Exchequer committed in Parliament last week that *"Whatever extra resources our NHS needs to cope with coronavirus – it will get."* So financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

COVID-19 presents the NHS with arguably the greatest challenge it has faced since its creation. Our health service - through our skilled and dedicated staff - is renowned for the professional, flexible and resilient way that it responds to adversity. Please accept our sincere thanks for your leadership, and that of your staff, in what is going to be a highly challenging period.

This is a time when the entire NHS will benefit from pulling together in a nationally coordinated effort. But this is going to be a fast-moving situation requiring agile

responses. If there are things you spot that you think we all should be doing differently, please let us know personally. And within the national framework, do also use your discretion to do the right thing in your particular circumstances. You will have our backing in doing so.

With best wishes,



Sir Simon Stevens
NHS Chief Executive



Amanda Pritchard
NHS Chief Operating Officer

ANNEX: CORONAVIRUS COST REIMBURSEMENT

This guidance sets out the amended financial arrangements for the NHS for the period between 1 April and 31 July. These changes will enable the NHS and partner organisations (including Local Authorities and the Independent Sector) to respond to COVID-19. We will continue to revise this guidance to reflect operational changes and feedback from the service as the response develops.

We will shortly be making a payment on account to all acute and ambulance providers to cover the costs of COVID-19-related work done so far this year, with final costs for the current financial year being confirmed as part of the year end processes. This initial payment will be based on information already submitted by providers. Future payments will be based on further cost submissions.

All NHS providers and commissioners must carefully record the costs incurred in responding to the outbreak and will be required to report actual costs incurred on a monthly basis. Accurate record keeping during this time is crucial - record keeping must meet the requirements of external audit, and public and Parliamentary scrutiny.

To support reimbursement and track expenditure we will in due course be asking all relevant organisations to provide best estimates of expected costs from now until the expected end of the peak outbreak. We will provide further guidance with relevant assumptions in order to support you in making these estimates.

REVENUE COSTS

Contractual payments and provider reimbursement

We are suspending the operational planning process for 2020/21.

We will provide all NHS providers a guaranteed minimum level of income reflecting the current cost base on the following basis:

- a) Commissioners should agree block contracts with the NHS providers with whom they have a contract (NHS Trusts, Foundation Trusts, Mental Health, Community and Ambulance trusts) to cover the period 1 April to 31 July. This should provide a guaranteed monthly payment. For CCGs the value of this payment will be calculated nationally for each CCG/provider relationship. This figure will be based on the average monthly expenditure implied by the provider figures in the M9 Agreement of Balances return plus an uplift that allows for the impact of inflation (including pay uplifts and CNST) but excluding the tariff efficiency factor. It will not include activity growth. For mental health trusts the uplift will include an additional sum consistent with

delivering the Mental Health Investment Standard. The monthly payment should include CQUIN and assume 100% delivery.

- b) Trusts should suspend invoicing for non-contracted activity for the period 1 April to 31 July. A sum equivalent to the historical monthly average will be added to the block contract of the provider's coordinating commissioner. Providers should continue to record all activity including NCAs in SUS in the normal way.
- c) A national top-up payment will be provided to providers to reflect the difference between the actual costs and income guaranteed by steps 1 and 2 where the expected cost base (which will be calculated as the average monthly expenditure over the period November to January uplifted for inflation) is higher. The Financial Recovery Fund and associated rules will be suspended during this period. The top-up payment will take into account individual provider CNST contributions compared to that funded in the allowance for cost inflation.

We will provide these numbers to Commissioners and Providers on Monday 23 March.

Providers should claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. These reasonable costs should include:

- a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.
- b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).
- c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which aren't otherwise covered under normal practice; and
- d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

Claims should be made on a monthly basis, alongside regular monthly financial reports. This should provide sufficient funds for providers to deliver a break-even

position through the period and will provide the basis against which we will monitor financial performance.

We will monitor the impact of any changes in income levels from non-NHS services, in particular from local authorities. Providers should escalate to regional teams as appropriate.

The payments made by commissioners under block contract arrangements should not be revised to reflect any short falls in normal contractual performance during this period. The majority of NHS acute providers are already exempt from the majority of contract sanctions; for the duration of the outbreak until further notice any remaining contract sanctions for all NHS provider groups are to be suspended.

It is important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision.

The arrangements described above should mean there is minimal requirement for interim working capital support during this period. Providers that believe they require supplementary working capital support should follow the normal procedure to access such support.

Funding for commissioners

Commissioner allocations for 2020/21 have already been notified as part of operational planning and will not be changed. However, in assessing individual commissioner financial positions and affordability we will take into account:

- a) The impact of the block contracting approach set out above including both the cost of removing the tariff efficiency factor and the benefit of excluding activity growth from the calculation.
- b) Expected reductions in investments for service developments
 - the temporary arrangements for non-contracted activity, transferring funding to make sure that lead commissioners have adequate funds to pay providers; and
 - the costs of additional service commitments as described below for example for out of hours provision, additional NHS111 investment, purchase of step-down beds and provision of rapid discharge/ additional social care capacity.
- c) We will also be reviewing planned transformation initiatives, and where we consider that these will not be able to proceed during the coronavirus emergency we will reflect this in the distribution of transformation funding.

- d) In addition, a number of NHS commissioners are dependent on additional central support to fully cover their expenditure. NHSE/I will calculate a central top up payment on broadly the same basis as FRF to cover the difference between allocations as set out above and expected costs.

Financial Governance

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance. Any financial mismanagement during this period will be dealt with in exactly the same way as at any other time.

We recommend that NHS organisations undertake an urgent review of financial governance to ensure decisions to commit resources in response to COVID-19 are robust. Naturally, all organisations should test the resilience of their finance functions and business continuity plans to make sure that the most important elements (running payroll, paying suppliers, core reporting) can continue even with significant staff absences. We are also asking you to consider the resilience of your fraud prevention arrangements.

As normal financial arrangements have been suspended, no new revenue business investments should be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Where costs have already been committed or contractual commitments entered into, providers should agree an approach with NHSE/I as above.

Normal consultancy approval and agency reporting requirements must be maintained during this period.

SPECIFIC ADDITIONAL FUNDING CONSIDERATIONS

Purchase of enhanced discharge support services

CCGs will be asked to work with their local authority partners to commission additional out-of-hospital care and support capacity, in particular to facilitate step down of patients from secondary care and so free up acute beds. These are expected to be a blend of care home beds, hospices, and home-care support.

Detailed operational guidance for the procurement and management of these beds will be issued separately including more detailed finance guidance. To make sure that funding decisions do not restrict the pace of discharges, additional resources will be provided to pay for the community bed or a package of care post-discharge for any

patient that needs it. New guidance will also ensure that eligibility assessments do not delay new care packages being put in place. We will continue to review this approach and will ask CCGs and local authorities to move to standard commissioning and funding routes once the impact of Covid-19 sufficiently diminishes – you should plan therefore on the basis of an average length of care package.

Additional funding will be provided based on monthly cost returns from CCGs.

Specialised services

As described above, Specialised Services contracts will follow the same principles as CCG commissioned activity, and block values will be based on the average 2019/20 expenditure up to month 9, with an uplift to recognise the impact of pay uplifts and other cost increases.

Arrangements for pass through Drugs and Devices costs will continue to operate as currently on a cost and volume basis, to ensure that providers do not face any financial consequences of any increases in activity or cost.

Specialised providers will be required to respond to the most serious cases of COVID-19 through the provision of High Consequence Infectious Disease units, Extracorporeal Membrane Oxygenation services and other specialised care functions. Any specific investments and costs incurred by these units are being coordinated through the National Highly Specialised team.

NHS 111

NHS 111 has been commissioned nationally to provide a dedicated Covid-19 response service. This service will continue to be contracted for and funded nationally. In addition, having reviewed the pressures on the wider NHS 111 service additional funding will be released from NHSE/I via lead commissioners, who will then make necessary arrangements for payment to NHS 111 providers.

General Practice

The key principle is that from 1 April we free up practices to prioritise workload according to what is necessary to prepare for and manage the outbreak, and therefore guarantee that income will be protected if other routine contracted work has to be substituted. This does not prevent us from continuing to measure activities (for example those undertaken with QOF) but it ceases to put 2020/21 income at risk for performance.

We will make sure that funding does not influence clinical decision making by ensuring that all GP practices in 2020/21 continue to be paid at rates that assume they would

have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of QoF, DES and LES payments.

CCGs should plan to make payments on this basis. NHSE/I will reimburse any additional costs as part of our wider finance agreement on Covid-19.

Out of Hours Provision

CCGs have been asked to procure additional GP out of hours provision in order to provide home-based care for any patients that have tested positive for coronavirus in the community. CCGs will be reimbursed for the additional costs incurred in delivering this service through the allocations process. CCGs will be required to submit a monthly return of additional cost incurred which will provide the basis of additional payments. To keep the administrative burden to a minimum, where a CCG has contracted for this service on behalf of itself and others, reimbursement will be directed through the lead CCG.

Community Pharmacy

Where required, CCGs will be reimbursed for the following:

- a) An NHS Urgent Medicines Supply Service for patients whose General Practice is closed.
- b) A Medicines Delivery Service to support Covid-19 positive and vulnerable patients self-isolating at home.
- c) Payments to contractors who are required to close due to Covid-19 related reasons.

Optometry and dental

For the time being we expect that funding for dentistry and optometry will continue in line with existing contractual arrangements using assumptions rolled over from 2019/20 where required. We will keep this under review and address any issues as they arise.

Third and Independent Sector Providers

Details of reimbursement for any additional services to be procured from the third sector or from independent sector organisations will be issued in due course.

CAPITAL COSTS

NHSE/I will shortly issue indicative capital allocations for 2020/21. Additional capital expenditure will be required to support our response to the virus in a number of areas, including purchase of pods, capital modifications to existing estate, purchasing of ventilators and other medical equipment, and IT assets to enable smarter working including remote consultations. In a number of cases NHSE/I may bulk-purchase assets to secure the necessary resource as quickly as possible. However, this will not always be practical or desirable, so below are the arrangements for providers and commissioners to access capital in relation to the COVID-19 response. The key criteria against which we will assess claims are:

- a) The proposed expenditure must be clearly linked to delivery of our COVID-19 response;
NHS
- b) In the case of asset purchases, the asset must be capable of being delivered within the expected duration of the outbreak; and
- c) In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.

Commissioner capital

We anticipate that individual claims for capital expenditure by commissioners will fall within the delegated budgetary limits for NHSE/I of £10m. Any requests for capital expenditure by commissioners including any assets being purchased on behalf of general practice should be relayed to NHSE/I regional teams for assessment with the national team, following which the required capital allocation will be issued.

Provider capital

We anticipate that individual claims for capital expenditure by providers will fall within the delegated budgetary limits for trusts of £15m. Any requests for capital expenditure by providers should be relayed to NHSE/I regional team for rapid assessment with the national team to enable swift decision making and disbursement of cash where appropriate. PDC charges will not be levied on any funding supplied in connection with COVID-19.

Summary

Group	Service line	Funding method
Revenue costs		
All NHS organisations	Contracting basis	All providers to move to block contract,
	Self-isolation of workers	To be directly reimbursed as required
	Increased staff costs in the event of sick or carer's leave	To be directly reimbursed as required
	Other additional operating costs	Reasonable costs to be reimbursed
Acute providers	Pod provision	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Laboratory costs	To be directly reimbursed as required
CCGs	Purchase of step-down beds	Final 19/20 payment based on cost submissions Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Out of Hours (primary care) capacity increase	Additional allocations to be paid to CCGs to pass on to providers
Specialised services	Patient admissions	To be funded through block contractual payments
	Drugs costs	Payments for drugs not included in tariff will continue in the normal way
Ambulance providers	Additional PPE and cleaning	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
Community	Swabbing services	Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions

Group	Service line	Funding method
NHS 111	National CRS function	Costs to be reimbursed nationally
	Additional local 111 funding	Additional allocations to be paid via CCGs where agreed
Capital costs		
Acute providers	Equipment and estate modification as required	PDC allocation from DHSC to provider trust
CCGs (including primary care)	Equipment as required	NHS England allocation to CCGs funded via DHSC mandate adjustment

TRUST BOARD - PUBLIC REPORT SUMMARY

Title of report: Sustainable Development Management Plan	<input checked="" type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input type="checkbox"/> Information
Date of Meeting: 25 th March 2020	Item 9, report no. 06
Responsible Executive Director: Janice Sigsworth, Director of nursing Bob Klaber, Director of research, strategy and innovation	Author: Hugh Gostling Director of estates and facilities
<p>Summary:</p> <p>Following a thorough evaluation of proposals received in regards to support and assistance with development of a Sustainable Development Management Plan (SDMP), Sussex Community NHS Foundation Trust's (SCFT's) sustainable healthcare team was commissioned in 2019 to work with us to develop an SDMP using their award winning Care Without Carbon (CWC) framework. The SDMP is now at a final draft stage following a series of stakeholder meetings and workshops.</p> <p>Imperial College Healthcare's SDMP is aiming to be a Board approved plan outlining the organisation's aims, objectives, plans and priorities for improving their local and global environmental and socio-economic impacts. This is in conjunction with setting out a plan of action to achieve clear and measurable targets. By delivering care in a more sustainable way, and supporting our staff and patients to live more sustainable lifestyles we are enabling better health outcomes in our community.</p> <p>In the SDMP we set clear commitments to cut our environmental impact, reduce operating costs and improve wellbeing, covering each area of the triple bottom line of sustainability. Sustainability is directly linked to resource management, and the key drivers are:</p> <ul style="list-style-type: none"> • The climate emergency is a health emergency – as a healthcare provider we are a first responder to climate change. • The NHS Long Term Plan – sets out a number of requirements for NHS Trusts focussing on carbon reduction, air pollution and plastic reduction. • A Sustainable Development Strategy for the NHS, Public Health and Social Care Systems (2014) • The NHS standard contract mandates that all providers have a board approved SDMP; • An SDMP may be asked for by commissioners as evidence of our approach to Social Value; • NHS Improvement & NHS England expects all NHS providers to have a Board approved SDMP and this is seen as a marker of a well led organisation. • Improving the sustainability of the health and social care system can improve the health of its workforce and community. • There is a strong business case for taking action to become more sustainable, for example cutting energy and water use and recycling can generate significant savings. • The NHS must help mitigate the negative impact of climate change on health as a large organisation and an anchor institution. <p>The SDMP is produced under the Care Without Carbon framework, covering seven elements (see item 4 of the report) – each of which includes high level targets and actions. The overall aims for the Trust are to reduce Trust carbon emissions by 57% by 2025 against a 2007 baseline in line with the NHS Long Term Plan reduce costs through more efficient use of resources, and improve wellbeing through promoting healthy, low carbon lifestyles. The SDMP also directly supports the Trust's vision of 'better health, for life' as well as each of the Trust's three strategic goals as set out in the 2019 Trust strategy.</p>	

<p>A 'Value at Stake' analysis has been incorporated into the SDMP which projects the potential CO₂ and financial savings which can be realised through the implementation of the strategy. A project charter for the SDMP has also been produced and is presented in the appendix of this paper. This charter sets out the scope and goals for the SDMP and the roadmap for delivery. The specific projects arising from the delivery of the SDMP will utilise the Imperial Way Model of quality improvement. A stakeholder group will be established in 2020/21 to prioritise the actions and present a project plan in October 2020.</p>
<p>Recommendations: The Board is asked to formally approve the Sustainable Development Management Plan as recommended by the Audit, Risk and Governance Committee.</p>
<p>This report has been discussed at:</p> <ul style="list-style-type: none"> • Executive Operational Performance Committee • Audit, Risk & Governance Committee
<p>Quality impact: There are very compelling links between the sustainability and quality improvement agendas in the health service. SDMPs form an important part of sustainable healthcare delivery; ensuring services remain fit for purpose today and for the future. The SDMP identifies reduction opportunities, financial savings and addresses national priorities, such as carbon reduction. Health and care organisations can use their SDMP to describe their plans to improve prevention and the wider determinants of health in the communities they serve. The CWC model developed by SCFT also highlights the strong links between environmental quality and health and wellbeing and utilises this as an effective means of engaging staff in wellbeing, cost improvement, productivity and other quality improvement opportunities.</p>
<p>Financial impact: The SDMP identifies opportunities to deliver cost improvements through a programme of environmental improvement and health and wellbeing interventions and it also sets out a high-level business case for onward investment in the programme.</p>
<p>Risk impact and Board Assurance Framework (BAF) reference: The full length version of the NHS standard contract mandates that all providers are required to have an SDMP in place. An effective SDMP can help reduce a range of risks to the organisations, including:</p> <ul style="list-style-type: none"> • The SDMP describes the actions the Trust needs to take to reduce its environmental impact (in particular its carbon footprint) in line the NHS Long Term Plan (57% CO₂ reduction by 2025). • An SDMP may be asked for by commissioners as evidence of the Trust's approach to Social Value. • NHS Improvement and NHS England expect all NHS providers to have a Board approved SDMP as these plans are considered a good measure of a well-led organisation. • Public Health England view SDMPs as evidence of a Trust's commitment to local public health outcomes. • An effective SDMP will demonstrate a mature and holistic approach to resource stewardship to patients and tax payers, enhancing the organisation's reputation within its local community. • The SDMP will create opportunities for resource efficiency and cost improvement, which may otherwise be missed.
<p>Workforce impact (including training and education implications): This is covered in the Culture element of the SDMP which focusses on informing, empowering and motivating people to take ownership of sustainable healthcare. Recommendations within this section which particularly link with workforce are as follows:</p> <ul style="list-style-type: none"> • Review HR policies and processes and consider opportunities to include sustainability objectives in staff induction, development and appraisal processes. Encouraging all staff to consider sustainability in their daily work. • Development of a sustainability training programme for all levels of staff and deliver at a range of stakeholder events.
<p>Has an Equality Impact Assessment been carried out or have protected groups been considered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable</p>
<p>How have patients, the public and/or the community been involved in this project and what changes were made as a result?</p>

<p>Patients, the public and the community have not been directly engaged as part of this work, but will be as part of the delivery of the SDMP.</p>
<p>What impact will this have on the wider health economy, patients and the public? This will have a positive impact on the wider health economy, our patients and the public, the main aim of the document is to deliver care in a more sustainable way and support staff and patients to live more sustainable lifestyles therefore enabling better health outcomes for patients.</p>
<p>The report content respects the rights, values and commitments within the NHS Constitution <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Trust strategic goals supported by this paper: The SDMP directly supports the Trust's vision of 'better health, for life' as well as each of the three strategic goals set out in the 2019 Trust strategy:</p> <ul style="list-style-type: none"> • to help create a high quality integrated care system with the population of north west London; • to develop a sustainable portfolio of outstanding services; and • To build learning, improvement and innovation into everything we do.
<p>Update for the leadership briefing and communication and consultation issues (including patient and public involvement):</p> <ul style="list-style-type: none"> ▪ This SDMP sets clear commitments to cut the Trust's environmental impact, reduce operating costs and improve wellbeing through promoting healthy, low carbon lifestyles. ▪ The framework for delivery of the Sustainable Development Management plan is called Care without Carbon and covers 7 elements. ▪ The Trust's overarching target is 57% carbon reduction by 2025 against a 2008 baseline in line with the NHS Long Term Plan. ▪ read the document and understand how sustainability can be implemented in your area. ▪ Share the SDMP with your teams. ▪ Should senior managers share this information with their own teams? <input checked="" type="checkbox"/> Yes

Sustainable Development Management Plan, Care without Carbon

1. Executive Summary

- 1.1. The Sustainable Development Management Plan (SDMP), Care without Carbon, establishes a set of principles and targeted interventions aimed at ensuring that the high quality of care we are providing today is available tomorrow. As such, we are working with three key aims in mind:
 - Minimising our impact and having a positive effect on the environment
 - Supporting staff wellbeing to enable a happy, healthy and productive workforce
 - Working towards long term financial sustainability.
- 1.2. At Imperial College Healthcare, our framework for sustainable healthcare is called Care Without Carbon, This sets out how we will achieve our sustainability commitments by working across seven elements:
 - Leadership – leading the way for sustainable policy and practice
 - Buildings – providing the workspace for low carbon care delivery with wellbeing in mind
 - Journeys – maximising the health benefits of travel and minimising environmental impacts
 - Circular economy – creating and supporting an ethical and resource efficient supply chain
 - Wellbeing – creating a better working life for our people
 - Future – working together to build a strong local health economy that serves our community now and in the future
 - Culture – Informing, empowering and motivating people to achieve sustainable healthcare

2. Purpose

- 2.1. To provide a summary, including key points and savings derived from the Imperial College Healthcare Sustainable Development Management Plan.

3. Background

- 3.1. By delivering care in a more sustainable way, and supporting our staff, patients, carers and citizens to live more sustainable lifestyles we are enabling better health outcomes in our community.
- 3.2. Sustainability is shorthand for effective resource management. In the NHS we can identify three key resource challenges:
 - a social challenge: finding new ways of delivering care that reduces demand and empowers patients as well as looking after the health and wellbeing of our 1.5m NHS and social care staff;
 - an environmental challenge: the NHS is the largest public sector emitter of CO₂ in the UK; and
 - a significant financial challenge, with demand on our services and an aging estate outpacing funding.

The sustainability programme will support us in meeting these complex and interrelated challenges.

Simon Stevens, NHS England CEO recently described the climate emergency as a 'health emergency' and reiterated the need for the NHS to be the change it wants to see. As a healthcare provider we are a first responder to climate change – it is our patient community that is most affected and we must respond.

The NHS Long Term Plan sets out a number of requirements for NHS Trusts focussing on carbon reduction, air pollution and plastic reduction. Key to this is a commitment to the Climate Change Act (2008) target to more than halve emissions by 2025.

- 3.3. Imperial College Healthcare is one of the largest Trusts in England. In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also require movement of staff and patients across a substantial area of north-west London and

purchase a wide range of equipment and services. All of these activities generate CO₂ emissions, which are linked to climate change and can be collectively summarised as the Trust's carbon footprint.

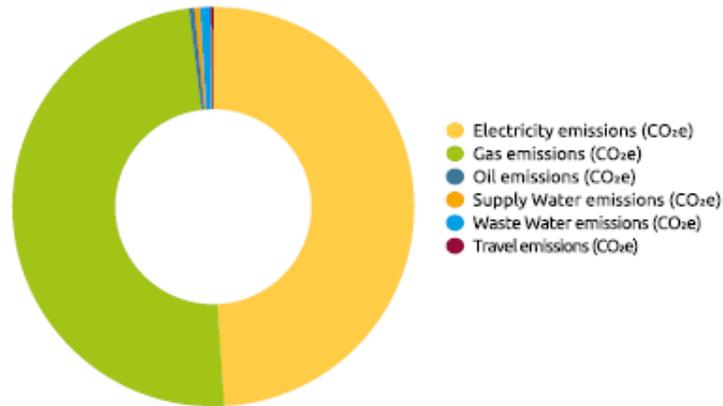


Figure 1: Imperial College Healthcare Carbon Footprint 2018/19

4. Summary/Key points

4.1. Our Care Without Carbon approach, addresses seven key elements of NHS activity, to define our overall objectives and action plans between now and 2025, including key success measures and these are illustrated in both the graphic and table below:



Figure 2: Care Without Carbon seven elements of sustainable healthcare

<u>CWC Element</u>	<u>Key success measure for 2025</u>
Leadership	To embed sustainable development principles into core business and reflect this in our 2023 Trust strategy.
Buildings	57% reduction in CO ₂ e from our buildings from a 2007 base year
Journeys	57% reduction in all measureable travel CO ₂ e by 2025.
Circular Economy	Measurable reduction in overall waste volumes, 60% offensive waste, 75% recycling, and zero waste to landfill.
Culture	100% of Trust staff engaged with sustainability with measureable benefits.
Wellbeing	Reduce sickness rate to 3% and improve staff survey results relating to wellbeing.
Future	To work with our NHS partners across our STP to reduce emissions from the system in line with the targets set out in the Climate Change Act.

5. Options appraisal including financial appraisal (as relevant)

- 5.1. By delivering this SDMP to become a more sustainable healthcare provider, we are directly supporting our vision to deliver better health, for life. We can achieve immediate health and wellbeing benefits, significant cost savings and considerably reduce its impact on the environment. The SDMP, if delivered in full will realise the following benefits:
- A reduction of **27,500 tonnes CO₂e** by 2025.
 - Reduced sickness absence and stress among staff.
 - Improved workforce health with an increased proportion participating in physical activity during the working day, including travelling to work.
 - Greater ability to ensure appropriate care is available for vulnerable patients during heatwaves, floods and other extreme weather events caused by climate change.

6. Conclusion and Next Steps

- 6.1. By taking action to reduce our emissions as set out in the SDMP, the Trust can expect to realise significant CO₂ reductions and costs savings alongside improvements in wellbeing.
- 6.2. In terms of next steps the SDMP contains an action plan to guide delivery of the strategy during the first year of implementation. The delivery should be driven by an internal group with quarterly meetings and feedback on targets and related KPIs.

7. Recommendations

- 7.1. The Trust Board is asked to formally approve the Sustainable Development Management Plan.

Sustainability Development Management Plan

Exec Sponsor: Bob Klaber		SRO: Hugh Gosling		Clinical Lead: XX		Project Leads: Vikas Ahuja others to be identified	
Problem Statement						Team Alignment	
In delivering its services, ICHT consume a significant amount of energy and water and produce a large volume of waste. We also require movement of staff and patients across a substantial area of north west London and purchases a wide range of equipment and services. All of these activities generate CO ₂ (carbon dioxide) emissions, which are linked to climate change, and can be collectively summarised as the Trust's carbon footprint. Our absolute carbon footprint has reduced year-on-year since 2015/16, with an overall reduction of 18%. This is despite an increase in our electricity and gas consumption. The impetus to reduce our carbon emissions and associated costs is clear, and we recognise the urgency of taking action now in order to meet our 2025 commitment.						Clinical Directorates	
						MIC Division	D
						SCC Division	D
						WCC& Division	D
Project Goals						Corporate Divisions	
Deliverables		See page 33 and 34 for the 12 month action plan.				Estates & Facilities	D
Outcome Metric		CO ₂ e from our buildings, travel, waste volumes and offensive waste				People & OD	S
Baseline		54,402 tonnes CO ₂ e in FY2015/16				QI	S
Vision		Carbon Footprint reduction of 51% by 2025		Hard Goal		Procurement	S
						Communications	D
Project Scope							
		Is			Is not		
What	Development and delivery of a 12 month and longer term strategy to reduce CO ₂ e by 2025.				Implementation of a strategic plan in the first instance.		
Where	Across all ICHT sites and departments.				Sites outside of the remit of ICHT.		
When	Strategy to be completed by end of FY20/21 for implementation until FY2025.				Actions will continue post FY2025, however reduction must be achieved by 2025.		
Who	Implementation of a Sustainability Steering Group reporting to Board annually and Executive Committees.				Future work includes working with STP partners and stakeholders and other Trusts within STP area.		
Key Milestones					Financials		
				Target completion date		Investment Required	Savings Opportunity
TBC						£0k in FY20/21	TBC
TBC							

Project Architecture





Our Sustainable Development Management Plan

Delivering better health, for life

2020-2025



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Our Sustainable Development Management Plan at Imperial College Healthcare NHS Trust has been developed in partnership with Sussex Community NHS Foundation Trust's sustainability team using their framework for sustainable healthcare, Care Without Carbon

Welcome

Welcome to the Imperial College Healthcare NHS Trust Sustainable Development Management Plan, Care Without Carbon.

This Sustainable Development Management Plan (SDMP), Care Without Carbon, establishes a set of principles and targeted interventions aimed at ensuring that the high quality of care we are providing today is available tomorrow. As such, we are working with three key aims in mind:

1. Minimising our impact and having a positive effect on the environment
2. Supporting staff wellbeing to enable a happy, healthy and productive workforce
3. Working towards long-term financial sustainability

At Imperial College Healthcare, we are fully committed to becoming a more sustainable healthcare provider and we invite you to join our journey and help us achieve this.

Our vision of maintaining better health, for life is intrinsically linked to developing a truly sustainable approach to healthcare.

Maintaining high quality, sustainable acute and specialist services across north west London to a community of over one million people each year requires us to make best use of the resources we have - by being efficient and innovative in everything we do. Our SDMP is central to achieving this.

Our target is to work with our three key aims in mind to match the global Climate Change Act targets set out in the NHS Long Term Plan, with a reduction in carbon footprint of 57% by 2025 from a 2007 base year.

We set clear commitments to cut our environmental impact, reduce operating costs and improve wellbeing through promoting healthy, low carbon lifestyles.

At Imperial College Healthcare, our framework for sustainable healthcare is called Care Without Carbon. This sets out how we will achieve our commitments by working across the seven elements:

- Leadership – leading the way for sustainable healthcare policy and practice
- Buildings – providing the workspace for low carbon care delivery with wellbeing in mind
- Journeys – maximising the health benefits of travel and minimising environmental impacts
- Circular economy – creating and supporting an ethical and resource efficient supply chain
- Culture – informing, empowering and motivating people to take ownership of sustainable healthcare
- Wellbeing – creating a better working life for our people
- Future – working together to build a strong local health economy that serves our community now and in the future

The Case For Sustainable Healthcare

The links between climate and health are clear. According to The Lancet, climate change is the biggest global health threat of the 21st Century – but tackling it presents the greatest opportunity to improve health that we will see in our life times.

Delivering better care

Health and sustainability go hand in hand.

By delivering care in a more sustainable way, and supporting our staff, patients, carers and citizens to live more sustainable lifestyles we are enabling better health outcomes in our community. This directly links with the strategic work to position the Trust as an anchor institution within the local area.

We are working firstly to minimise the need for healthcare through supporting prevention and self-care; and secondly to reduce the environmental or health impact of any remaining activity, while at the same time improving health outcomes. These links are illustrated in Figure 1 on the following page.

Meeting our resourcing challenges

Sustainability is shorthand for effective resource management. In the NHS we can identify three key resource challenges:

1. a social challenge: finding new ways of delivering care that reduces demand and empowers patients, as well as looking after the health

and wellbeing of our 1.5m NHS and social care staff;

2. an environmental challenge: the NHS is the largest public sector emitter of CO₂ in the UK; and

3. a significant financial challenge, with demand on our services and aging estate outpacing funding.

This sustainability programme will support us in meeting these complex and interrelated challenges.

Delivering against our Trust vision

As such, this SDMP directly supports our vision of **better health, for life** by directly linking with each of the Trust's three strategic goals as well as each of the Trust's three strategic goals as set out in the 2019 Trust strategy:

- to help create a high quality integrated care system with the population of north west London;
- to develop a sustainable portfolio of outstanding services; and
- to build learning, improvement and innovation into everything we do.

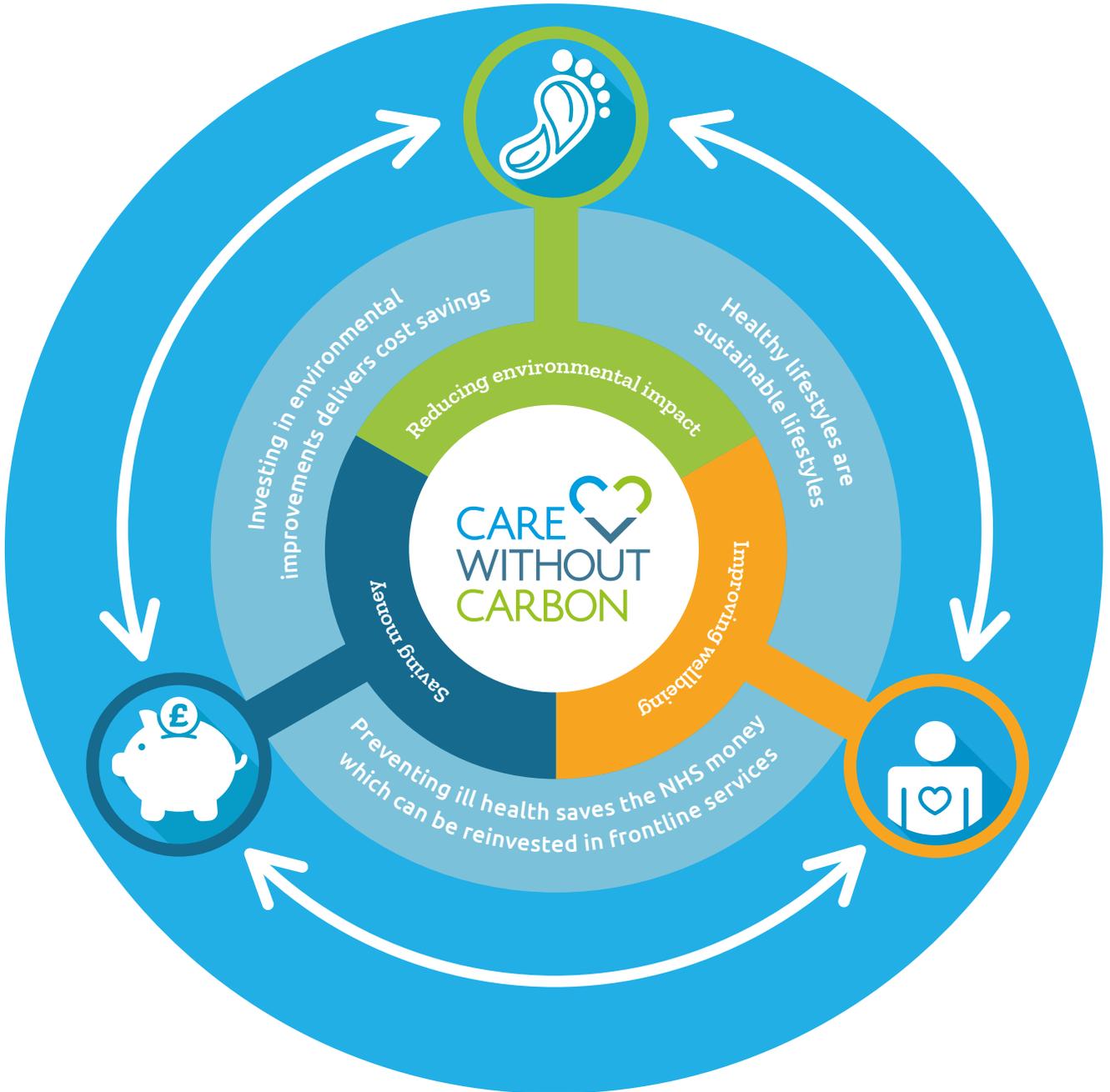


Figure 1: Care Without Carbon creates a virtuous circle of sustainable healthcare.

The key drivers for this SDMP are as follows:

Climate emergency = health emergency. Simon Stevens, NHS England CEO recently described the climate emergency as a "health emergency" and reiterated the need for the NHS to be the change it wants to see. As a healthcare provider we are a first responder to climate change - it is our patient community that is most affected and we must respond.

The NHS Long Term Plan. As the largest public sector contributor to climate change in Europe, the NHS has the potential to make a significant contribution to tackling climate change in the UK. The NHS Long Term Plan sets out a number of requirements for NHS Trusts focussing on carbon, air pollution and plastic reduction. Key to this is a commitment to the Climate Change Act 2008 target to more than halve emissions by 2025. Further to this the plan references trusts as anchor institutions, whereby long term organisational sustainability is tied to the wellbeing of the local population they serve.

A Sustainable Development Strategy for the NHS, Public Health and Social Care Systems (2014) reinforces the urgent need for all NHS organisations to take action to reduce their environmental impact and embed sustainability into their strategies, cultures and communities.

The NHS standard contract (full version) mandates that all providers have a Board approved SDMP.

An SDMP may be asked for by **commissioners** as evidence of our approach to Social Value.

NHS Improvement and NHS England expect all NHS providers to have a Board approved SDMP as these plans are considered a good measure of a **well led** organisation.

Improving the sustainability of the health and care system can improve the health of its workforce and community. For example, switching to walking instead of using the car increases physical activity and improves mental wellbeing while at the same time reducing the negative impacts of air pollution.

There is a strong business case for taking action to become more sustainable. By reducing energy and water consumption, reducing waste and recycling more and finding alternatives to motorised travel NHS organisations can realise significant financial savings. These can be reinvested into frontline care, redeveloping our aging estate and improving our working conditions.

The NHS must help to mitigate the negative impact of climate change on health. We have been feeling the affects of climate change in London for some years, with increasing temperatures, an increase in the frequency of extreme weather events (heatwaves and flooding), as well as a deterioration in air quality.

These changes in climate impact the way in which we deliver care - from reducing access to our premises for both service users and staff, to altering the health needs of our community.

The NHS must set an example as a leading public sector organisation. It needs to be conscious of delivering safe and cost effective healthcare whilst minimising the negative impact that it has on the environment - and on health. As an employer, service provider and procurer of goods and services, we can use our position and buying power to influence our patient community, partners and suppliers to adopt similar attitudes towards sustainability.

The Story So Far

Imperial College Healthcare provides acute and specialist healthcare in north west London. We're one of the largest NHS trusts in England, employing up to 12,000 dedicated staff and delivering care to over one million people each year. Our work incorporates five hospitals and a growing portfolio of community-based and digital services. As such, our patient community is a wide one, with our reach spreading from our diverse local community in north west London to further into the UK and abroad.

Our carbon footprint

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also require movement of staff and patients across a substantial area of north west London and purchases a wide range of equipment and services. All of these activities generate CO₂ (carbon dioxide) emissions, which are linked to climate change, and can be collectively summarised as the Trust's carbon footprint.

The carbon footprint (measured in tonnes CO₂e¹) associated with our services is illustrated in Figures 2-6 on following pages.

The Sustainable Development Unit (SDU) has published targets using a 2007 base year to ensure that NHS emissions targets coincide with the national emissions targets set out in the Climate Change Act. The Trust has therefore adopted 2007/08 as its base year for emissions.

¹ CO₂e refers to six greenhouse gases including carbon dioxide and methane. The NHS measures carbon footprint in CO₂e, in line with national and international conventions. This allows all six greenhouse gases to be measured on a like-for-like basis, which is important as some gases have a greater warming effect than CO₂.

Our absolute carbon footprint has reduced since 2007/08 with an overall reduction of 24%. This is despite an increase in our electricity and gas consumption.

The primary reason for this is the reduction in carbon intensity of grid electricity. Although this reduction in the grid emissions factor for electricity will continue over the coming years, it will not be sufficient to meet our 2025 carbon targets, and does not carry any cost reductions.

The impetus to reduce our carbon emissions and associated costs is clear, and we recognise the urgency of taking action now in order to meet our 2025 commitment.

Travel impacts

Travel is another component of our footprint. In 18/19, our staff travelled over 268,400 miles, through our hopper bus, our estates vehicles and through taxis and couriers. This figure currently excludes travel through our community services e.g. midwifery as data was not available.

We are working to improve the quality of our data for travel, in particular to include data for business travel outside of the areas identified (for example our community services) to ensure we have a true picture of our impact in relation to travel.

Air pollution is a key issue for our community in north west London, with emissions from petrol and diesel vehicles linked to a range of health problems from respiratory and heart conditions to impacting child development. Emissions also contain powerful greenhouse gases, which contribute to climate change.

Waste impacts

In addition to our carbon footprint we produced around 4,800 tonnes of waste in 2018/19, including general waste and healthcare waste. 30% of non-healthcare waste was recycled, with the remaining sent for energy recovery (zero waste to landfill). Of our healthcare waste, 26% is disposed of as offensive waste.

Although waste disposal produces greenhouse gases, we have not included these emissions in our carbon footprint, primarily due to the lack of a robust calculation methodology. However, we are committed to reducing the amount of waste we generate and finding more sustainable disposal options and this is addressed in our Circular Economy action plan later in this document.

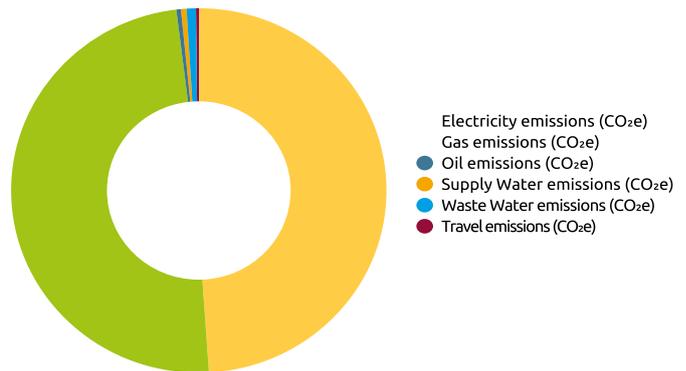


Figure 2: Our carbon emissions (tCO₂e) 2018/19

	2007/08	2016/17	2017/18	2018/19
Electricity (kWh)	59,076,028	54,757,547	56,038,735	56,987,818
Gas (kWh)	90,158,221	86,716,176	94,980,256	94,905,199
Oil (kWh)	743,339	658,070	1,248,875	565,174
Supply Water consumption (m3)	454,229	447,780	473,262	431,031
Waste Water consumption (m3)	406,125	425,391	449,599	409,479

Figure 4: Imperial College Healthcare utilities consumption data 2007/08 – 2018/19

	2007/08	2016/17	2017/18	2018/19
Electricity emissions (CO ₂ e)	29,726	24,604	21,543	17,507
Gas emissions (CO ₂ e)	16,698	15,956	17,492	17,459
Oil emissions (CO ₂ e)	199	182	345	156
Supply Water emissions (CO ₂ e)	156	154	163	148
Waste Water emissions (CO ₂ e)	288	301	318	290
Travel emissions (CO ₂ e)	83	83	83	83
Total (tonnes CO₂e)	47,150	41,280	39,944	35,643

Figure 5: Imperial College Healthcare carbon emissions 2007/08 – 2018/19

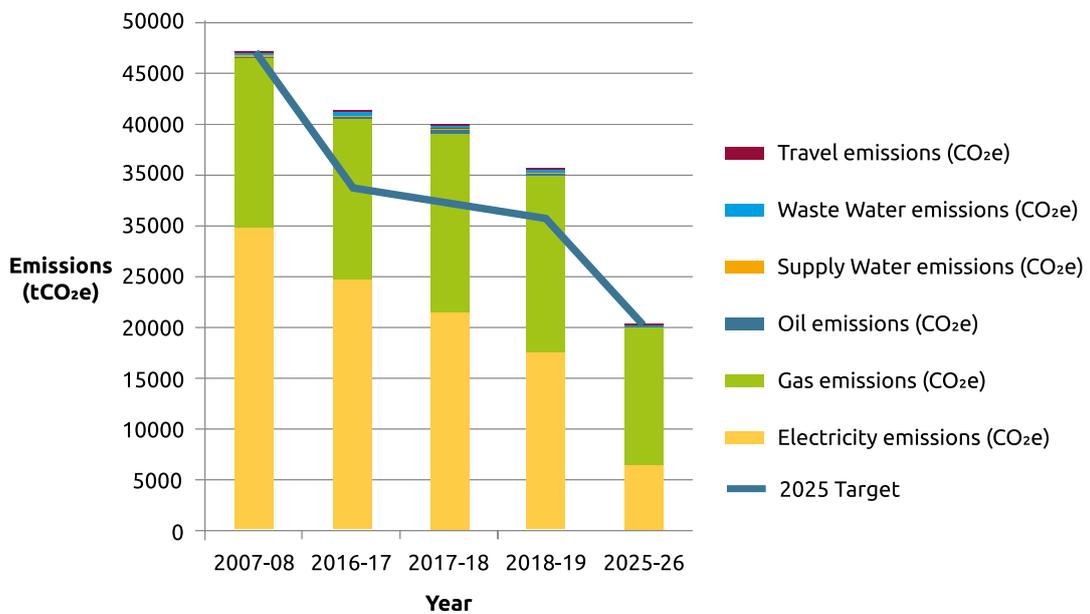


Figure 6: Our carbon footprint - trajectory to 2025

Although this is our first SDMP, we have made progress on sustainability in a number of key areas. For example, we have:

ENERGY EFFICIENCY: Implemented a range of energy and water efficiency projects since 2009/10, with projected lifetime savings of nearly £40m by 2025. This has included:

- Installation of a Combined Heat and Power (CHP) unit at the Hammersmith Hospital site. This will generate electricity on site, reduce our reliance on grid electricity and reduce our carbon emissions.
- A lift upgrade programme maximising efficiency of use through a 'traffic management system'.

ENERGY PERFORMANCE

CONTRACT (EPC): Progressed an EPC programme, aiming to work in partnership with an external provider to holistically identify and implement energy efficiency and carbon reduction opportunities across all of our sites.

EXTERNAL RECOGNITION: Been awarded a certificate of excellence for sustainability reporting by the Sustainable Development Unit, and short listed for Energy Live Personality Awards.

WASTE MANAGEMENT: Introduced the offensive waste stream across all sites, saving £60K per year and meeting best practice for segregation. Continuously improved recycling facilities including development of a new waste training programme.

SINGLE-USE MEDICAL DEVICE RECYCLING: Successfully worked in partnership with our waste contractors and RecoMed to introduce a recycling scheme for single-use PVC medical devices such as oxygen masks and tubing.

Following engagement with clinical and Facilities teams, this has been implemented in surgery and theatre areas at St Mary's Hospital and is due to be rolled out at Charing Cross Hospital from January 2020. Benefits include both cost savings and improving recycling levels of single-use plastics.

TELEHEALTH: Continued to develop telehealth technologies in a number of areas. For example:

- Through the Remote Radiologist programme, supporting consultants to work from across the globe.
- Setting targets across our STP area to increase virtual outpatient appointments over the next two years.

ELECTRONIC PATIENT RECORDS:

Been making significant progress with digitalisation of our patient records across the Trust, including legacy notes. This has reduced our requirement for paper use significantly.

CASE STUDY: anaesthetic gases

Anaesthetic gases have a significant impact on the environment, representing 5% of the carbon footprint for acute NHS trusts.

Some anaesthetics have a much higher carbon footprint than others however, so choosing lower impact alternatives can make a significant difference with no detrimental affect to patient care.

For example, switching from the most damaging anaesthetic gas, desflurane, to an such as sevoflurane (which has a lower carbon footprint by 20x). Or moving to intravenous anaesthetics for some patients, which also have a lower carbon footprint still.

Next Steps

Through this SDMP the Trust aims to maximise the impact of its efforts by developing a comprehensive and integrated set of plans that demonstrate our commitment to sustainability, reduce our impact on the environment and help the Trust become a more sustainable healthcare provider.

What we are trying to achieve with this Sustainable Development Management Plan?

A Sustainable Development Strategy for the Health, Public Health and Social Care System (2014) sets out four priority actions for individual NHS Trusts:

1. Establish a Board approved plan including carbon reduction, adaptation plans and actions across the sustainability agenda
2. Measure, monitor and report on sustainable development and adaptation performance
3. Evaluate performance to ascertain areas of strengths and opportunities for development
4. Engage staff, service users and the public to help support the development of a more sustainable and resilient health and care system

As such, this SDMP clarifies our sustainability objectives and sets out a plan of action to achieve clear and measurable targets.

NHS Trusts are also required to establish interim targets and trajectories to meet the provisions of the Climate Change Act and NHS targets.

Our aims and objectives

Our Care Without Carbon approach to sustainable healthcare addresses seven key elements of NHS activity, to define our overall objectives and action plans between now and 2025. These are illustrated over the page.

In the following section we have identified our commitments under each of the seven elements as well as a series of specific actions and the key success measures through which we will monitor our progress.

Care Without Carbon: seven elements for sustainable healthcare





1. Leadership

Leading the way (internally and externally) for sustainable healthcare policy and practice.

Our commitments

- We will incorporate sustainability into our Vision and Values, and into our corporate governance structures, ensuring effective, targeted action is possible at all levels of the Trust.
- We will monitor and measure our progress against this SDMP and adopt transparent public reporting as a fundamental principle for improvement and good governance.



Actions

KEY SUCCESS MEASURE FOR 2025: to embed sustainable development principles into core business and reflect this in our 2023 Trust strategy.

ACTIONS to 2025

Governance

- Appoint a Board Lead, Non-Executive Director Lead and Clinical Lead for sustainability.
- Provide a dedicated resource to support the delivery of this SDMP, and consider best mechanism for resourcing within individual departments.
- Form a Sustainability Steering Group to oversee the delivery of this SDMP. This multidisciplinary group will bring together the work stream leads and clinical representation to shape and develop the programme.
- Develop and gain Board approval each year for a 12 month sustainability action plan, highlighting specific activities and objectives for the year.
- Proactively develop projects and partnerships focussed on sustainability with our NHS partners within the STP region.

Integrating sustainability into Trust processes

- Facilitate a discussion with the Board and key stakeholders to support integration of sustainable healthcare principles including through delivery of the Trust's existing strategy.
- Integrate sustainability into QI training programme and methodologies, and consider the potential to integrate sustainability as an aspect of QI roles.
- Ensure that new and existing Trust strategies, policies and processes align with this SDMP's objectives, including the strategic work on anchor institutions.
- Integrate sustainability criteria into business cases, financial appraisals and service level business plans.

Integrating sustainability into clinical practice

- Engage with clinical colleagues to support the integration of our clinical sustainability principles into core business, and deliver against them.
- Engage with our patients, carers, citizens and communities on relevant sustainability issues to improve care and support environmental gains outside of Trust boundaries.

Measurement and Reporting

- Report to our Board on progress against this SDMP annually and to Executive Committee on a regular basis.
- Meet national sustainability reporting requirements, by submitting an annual sustainability return to the SDU and publishing a sustainability update in our Annual Report each year. This should include metrics that follow measurement for improvement principles.
- Benchmark ourselves against other NHS Trusts on a number of key sustainability indicators, including CO₂ reduction.



2. Buildings

Providing the workspace for low carbon care delivery with wellbeing in mind.

Our commitments

- > We will decarbonise our estate in line with our carbon targets and wider sustainability goals, and develop robust data management and reporting systems to monitor and report on progress.
- > We will raise awareness of climate change and communicate progress with our own CO₂e reduction efforts to our Board, our staff, our patients, our carers, citizens and communities.



Actions

KEY SUCCESS MEASURE FOR 2025: 57% reduction in CO₂e from our buildings from a 2007 base year

ACTIONS to 2025

Carbon, energy and water

- Continue the development of our Energy Performance Contract project to deliver significant cost and carbon savings to the Trust, ensuring they are in line with the carbon targets set out in this SDMP.
- Commit to and develop a long term strategy for becoming a zero carbon NHS Trust in line with Climate Change Act targets.
- Maintain comprehensive energy, water and carbon measurement and reporting systems that adhere to best practice and obtain independent, third party validation of our footprint each year.
- Review all suggested actions from the Recommendation Reports that accompany our Display Energy Certificates (DECs) to identify any energy conservation measures that could be easily implemented.
- Undertake sustainability surveys of our non-EPC sites/buildings to identify energy conservation measures, including addressing backlog maintenance where possible. Develop a capital investment strategy for these opportunities.
- Drive energy efficiency and CO₂e reductions, setting challenging energy efficiency targets for all new premises and refurbishments, leased and owned. Sites should be designed using Passivhaus principles and achieve BREEAM Excellent as a minimum. Each project should aim to achieve BREEAM Outstanding and Passivhaus certification where possible.
- Implement a process to ensure that any new significant capital expenditure is reviewed by a sub-group of the Sustainability Steering Group.
- Enhance energy management capabilities within the Estates and Facilities team to enable better management of consumption and costs and facilitate a programme of good housekeeping measures.
- Continue to deliver water saving solutions through the use of shared savings schemes (e.g Aquafund) where appropriate and develop an action plan to safeguard the Trust from future water shortages.
- Engage with Crown Commercial Services to look into the option of purchasing renewables backed/generated electricity. At the same time, explore the potential of Power Purchase Agreements to ensure both price-certainty and renewable-generated electricity.
- Increase use of on-site renewables to reduce carbon emissions and to increase resilience against volatile energy prices.

Working with our STP partners

- Continue to investigate collaborative working opportunities across the STP that will benefit the Trust, and the wider system as a whole.

Equipment and technology

- Recognising the ever increasing reliance on technology in healthcare,

Actions

ensure the increase in power requirement is minimised through procuring the most energy efficient equipment, moving to centralised power management and using thin client technology.

Developing a more healthy working environment

- Review estate utilisation with the aim of creating the most staff and patient friendly work environments with adequate space for “time out”, interview rooms and quiet space for confidential verbal and electronic communications.
- Ensure any changes to our property portfolio provide on-going improvements in working environment for staff and adequate facilities for break and rest periods. For any new build projects, standards such as the WELL standard should be considered as part of the business case.
- Undertake a review of hazardous substances used by the Trust and reduce to the lowest practicable level.
- Develop and implement a Healthy Food and Drink Policy aiming to increase access to healthy, sustainable food options for staff, patients, carers and visitors. This should include a greater emphasis on meat-free (lower carbon) options.
- Identify opportunities to use the green spaces across our estate to support staff wellbeing, patient recuperation and biodiversity alongside climate adaptation.



3. Journeys

Maximising the health benefits of our travel and transport activity whilst minimising environmental impacts.

Our commitments

- ▶ We will decarbonise our travel and transport operations and minimise the environmental and health impacts associated with the movement of staff and materials.
- ▶ We will maximise our contribution to staff and patient wellbeing through active travel, supporting a shift to more sustainable travel options that deliver additional environmental and health benefits.



Actions

KEY SUCCESS MEASURE FOR 2025: 57% reduction in all measurable travel CO₂e from a 2007 base year

ACTIONS to 2025

FOCUS ON: air pollution

Air pollution is linked to a number of health issues such as asthma, dementia, cardiovascular disease and COPD. It is estimated that air pollution related ill health costs the NHS around £20 billion per year. At the same time, one in 20 vehicles on the road are associated with NHS business.

In line with the requirements of the NHS Long Term Plan we will:

- Cut business mileage and fleet air pollutant emissions by 20% by 2023/24.
- Use low emission vehicles for at least 90% of our fleet including 25% Ultra Low Emissions by 2028.

In addition we will:

- Develop staff, patient and supplier engagement campaigns such as the Care Without Carbon Breathe Easy Campaign, raising awareness of the health impacts of air pollution and highlight the opportunities in acting differently e.g travelling more actively.
- Sign up to the Clean Air Hospitals Framework, pioneered by Great Ormond Street Hospital, to tackle local air pollution and support our wider patient care objectives.

Staff travel

- Develop a programme to move towards a culture of flexible working, including home working to cut staff travel and make better use of our estate. This should include consideration of staff engagement and technology requirements alongside a wider cultural transformation.
- Introduce an electronic claims system to improve quality and consistency of data relating to travel claims so that this can be incorporated into the Trust's carbon footprint reporting.
- Develop and operate a staff travel survey and undertake an analysis of expenses data to gain a better understanding of staff travel patterns and attitude to travel.
- Use this data to develop a Sustainable Travel Plan to minimise non-essential travel, decarbonise our travel and transport and support active travel across the Trust. This should support the roll-out and uptake of sustainable travel options including use of bikes, pool cars and electric/hybrid buses, taxis and other vehicles.

Trust fleet

- Undertake review of fleet vehicle procurement and deployment including our hopper bus and taxis to maximise utilisation of cleaner and more efficient vehicles.
- Review current lease car providers to ensure best value and introduce a cap on emissions across our fleet.

Actions

Using technology

- Continue to refurbish key meeting rooms across the Trust to enable videoconferencing and identify a preferred Trust supplier.
- Continue to explore and develop the potential for Telehealth and Health Informatics technologies, enabling patients to receive consultations in their own home and provide a more flexible and convenient service.
- Build on the success of existing projects such as the Remote Radiologist Programme to develop a culture of flexible working and make it possible for all staff to work remotely. This should include an engagement programme aiming to promote a culture of acceptance for smart working technologies such as videoconferencing and agile working to reduce non-essential travel.

Working with our STP partners

- Work with our NHS partners, local councils, voluntary groups and other stakeholders in our STP area to develop an area-wide approach to air pollution.
- Explore opportunities for rationalisation of courier services across our STP area.
- Continue to drive down paper use by continuing the roll out the Clinical Systems Paperless Strategy based on the HiMMs framework.



4. Circular Economy

Creating and supporting an ethical and resource-efficient supply chain.

Our commitments

- > We will work with our suppliers to reduce the environmental impact of our supply chain wherever possible and work towards a circular economy.
- > We will demonstrate a commitment to ethical trade by integrating ethical trade principles into our core procurement practices.



Actions

KEY SUCCESS MEASURE FOR 2025: measurable reduction in overall waste volumes, 60% offensive waste, 75% recycling and zero waste to landfill.

In order to support a more circular economy in the Trust, we need to:

- > take a joined up approach to purchasing, use & disposal of products;
- > integrate lifecycle analysis and sustainability criteria into our procurement decisions;
- > move towards a culture of repair and reuse; and
- > recover and regenerate products at end of life.

ACTIONS to 2025

Waste management

- > Develop and implement a Waste Management Action Plan to support delivery against SDMP targets and actions.
- > Ensure all estates and facilities staff are appropriately trained to support effective waste management, with defined responsibilities identified in both individual job descriptions and the new Facilities contract.
- > Develop a staff engagement campaign around waste to promote correct segregation of waste, improved levels of recycling and increased uptake of waste training. This should raise awareness of existing good practice within the Trust. Once completed this should be rolled out to engage with patients, visitors and our communities.
- > Update waste signage to reflect waste engagement campaign and this SDMP, ensuring a consistent approach is taken across all Trust sites.
- > Continue to deliver improvement projects to deliver against our SDMP targets. For example: replacing under desk bins with centralised recycling bins; introducing food waste collections in all staff kitchens.
- > Broaden our work with clinical teams to reduce waste in key areas such as theatres and pharmacy. This should include roll out of the RecoMed project (recycling of single-use medical devices such as oxygen masks) across all relevant sites.
- > Update the Waste Policy to provide: information on key SDMP waste targets; further clarity on correct segregation procedures in line with HTM 07-01; disposal mechanisms for all waste types (including WEEE, medical devices etc).
- > Ensure relevant suppliers have responsibility for implementation of the waste hierarchy, turning residual waste into a resource wherever possible. For example work with catering providers to implement coffee cup recycling schemes across all Trust sites.
- > Introduce KPIs for waste management, including site-by-site analysis to support better implementation of the waste hierarchy.

Sustainable procurement

- > Using procurement data, measure the carbon footprint of our supply chain and undertake a carbon "hotspots" analysis to help prioritise areas for improvement. Develop a programme of work to address these carbon "hotspots"; this should include working proactively with clinical teams and engaging in collaborative initiatives with key suppliers.
- > Develop our knowledge and understanding of ethical procurement opportunities within the NHS and put in place a programme of work to tackle key areas of impact.
- > Revise our procurement policy and procedures to reflect the targets of this SDMP and ensure it is clear when and how and when sustainability considerations should be taken into account during the procurement process.

Actions

- Introduce clear sustainability criteria and KPIs into tenders and new contracts, with evaluations considering the balance between environmental, social and economic outcomes.
- Work towards becoming a paperless trust by developing our digital capabilities, continuing to move over to electronic patient records, altering work processes and engaging with staff.

FOCUS ON: plastics

Plastic is an extremely useful material but its strength and durability can make it very difficult to dispose of. The NHS relies heavily on single-use plastic; as an example, between 2013 and 2018 the NHS in England used 609 million plastic cups. Through this programme we will:

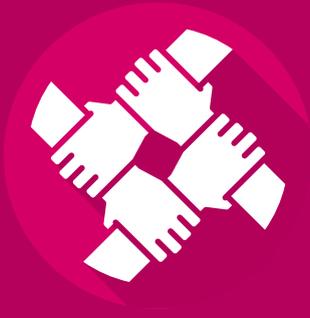
- Commit to and deliver against the NHS Plastics Pledge to reduce single use catering plastics over a period of three years:
 - » By April 2020, no longer purchase single-use plastic stirrers and straws, except where a person has a specific need
 - » By April 2021, no longer purchase single-use plastic cutlery, plates or cups made of expanded polystyrene or oxo-degradable plastics
 - » By April 2021, go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids
- Work with clinical and non-clinical teams to develop and deliver a Plastics Programme aimed at reduce the environmental and social impacts of plastic use in the Trust. This should focus on moving away from use of disposable items accross the Trust, reusing where possible and finally, finding recyclable alternatives. Consideration should be given to the overall carbon impact of any alternatives as plastic items may have a lower impact than paper alternatives.
- Work with our STP partners to develop a regional approach to plastic reduction.

Integrating our circular economy principles

- Develop working groups with key clinical departments to tackle specific areas e.g. waste reduction in theatres and pharmacy.
- Promote our Sustainable Procurement Policy to all potential suppliers and train staff to ensure that anyone procuring for our Trust understands its requirements.

Working with our STP and other partners

- Integrate sustainability objectives and criteria into STP-wide procurement planning and key tenders
- Continue to explore collaborative opportunities for resource sharing to reduce unnecessary purchase of new equipment. This could include establishing an STP-wide re-use network for furniture, stationery, clinical consumables and equipment, for example through Warp-it.
- Use our buying power within our STP region to engage with key national bodies such as NHS Supply Chain to strengthen the sustainability requirements for framework suppliers.



5. Culture

Informing, empowering and motivating people to take ownership of sustainable healthcare.

Our commitments

- › We will inform, empower and support our workforce to take action to deliver high quality care today that does not compromise our ability to deliver care in the future, ensuring this becomes integral to the way we operate.
- › We will embed sustainability into our HR policies and practices and ensure that staff development processes support a shift to more sustainable and resilient healthcare delivery with clear senior leadership.



Actions

KEY SUCCESS MEASURE FOR 2025: 100% of Trust staff engaged with sustainability with measurable benefits.

ACTIONS to 2025

Staff engagement

- Develop and launch a staff engagement programme in line with the Staff Engagement Roadmap in Appendix 2 to raise awareness of this SDMP, communicate core messaging and drive positive action for sustainability at every level of the Trust.
- Develop a champions programme to provide staff with a particular interest in sustainability with the opportunity to support this SDMP. This network would be a key conduit of information to staff across the Trust, enabling discussion around sustainability themes and implementation of change projects within teams and departments.
- Consider how best to integrate the objectives of this SDMP into our new Values and Behaviours framework and programme.
- Provide internal communication material to promote this SDMP and support implementation of action plans across the seven elements of Care Without Carbon. This should include creating a section on Trust intranet.
- Identify opportunities for an annual sustainability award to recognise those supporting the delivery of our SDMP.
- Design a Board leadership and development programme and train Senior Leaders in partnership with the NHS Sustainable Development Unit (SDU) to promote leadership competencies that encourage consideration of environmental impacts and projections alongside financial and health outcomes.

People processes

- Review HR policies and processes and consider opportunities to include sustainability objectives in our staff induction, development and appraisal processes, encouraging all staff to consider how to include sustainability considerations in their daily work.
- Develop a sustainability training programme for all levels of staff, and deliver at a range of stakeholder events and conferences e.g. divisional/departmental.
- Ensure all staff training and events are conducted in a lower-carbon manner that also supports staff wellbeing. This will include consideration of sustainable food offerings, minimising the need to travel and reducing printed materials.

Working with our STP and other partners

- Work with our NHS partners across the STP to identify and develop opportunities to coordinate staff engagement and behaviour change campaign activity.
- Participate in national sustainability campaigns such as NHS Sustainability Day and Clean Air Day.



6. Wellbeing

Creating a better working life for our people.

Our commitments

- > Through our new wellbeing programme, support staff coping with pressure to improve our mental and physical health and wellbeing.
- > We will reduce sickness absence and workplace stress and measurably improve the overall health and wellbeing of our workforce.



Actions

KEY SUCCESS MEASURE FOR 2025: reduce sickness rate to 3% and improve staff survey results relating to wellbeing.

ACTIONS to 2025

Measurement and reporting

- Undertake an analysis of wellbeing data across the Trust to support the development of our Wellbeing Action Plan. Identify ways to improve this data set in future years, including the potential for the implementation of a new wellbeing metric to provide more specific data to support our programme.
- Maximise the use of the annual staff survey by aiming to be an exemplar in levels of participation, ensuring analysis feeds directly into our Wellbeing Action Plans and reporting back to Board on progress.

Staff wellbeing

- Undertake a review of our People Strategy 2019-2022 to identify sustainability opportunities under each of the six strategic themes.
- Ensure that the commitments and goals set out in this SDMP are reflected in our new Wellbeing Plan and our subsequent annual Wellbeing Action Plans.
- Develop key areas of work to support our work to reduce staff sickness linked to Musculoskeletal and stress, while at the same time meet our environmental objectives, for example:
 - » Supporting an air pollution programme, aiming to cut local air pollution and promote healthy lifestyles through active travel.
 - » Supporting internal team activities or challenges such as implementing walking meetings or the Dare to Care Cycle Challenge.
 - » Working with Estates to develop our sites in support of staff wellbeing, including consideration of break spaces, improved green spaces, Green Gyms and outdoor meeting spaces.
 - » Continuing to develop our financial sustainability schemes, for example through credit union programmes, providing advice on saving for retirement and paying all staff the London Living Wage. This will promote financial inclusion, alleviate stress and support staff on lower incomes who cannot access credit.
- Work with local councils and stakeholders to develop Wellbeing Maps for each of our sites, identifying key facilities e.g. local walking routes, green spaces, cycle & public transport facilities and sustainable food outlets.

Actions

Communication and engagement

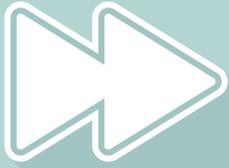
- Use staff communications and engagement on wellbeing issues as an opportunity to promote the links between the environment, productivity and health and wellbeing. This should include information for all new starters.
- Incorporate wider aspects of sustainability into Trust health and wellbeing programmes. This could include providing information on internal opportunities (green travel, champions programme, sustainability training) or opportunities from external organisations e.g. Living Streets, Energy Savings Trust etc.
- Link in with our sustainability engagement programme to ensure wellbeing messaging links in with the wider wellbeing programme. For example offering staff advice about active travel, hydration, wellbeing benefits of spending time in green spaces, mental resilience and sleep.

Volunteering and fundraising

- Identify opportunities for our volunteering days programme to support our sustainability goals, both for staff and for external organisations.

Working with our STP and other partners

- Work with our partners across the STP to identify opportunities to collaborate on staff health and wellbeing, for example through coordinated campaigns or the development of new metrics for measuring wellbeing.

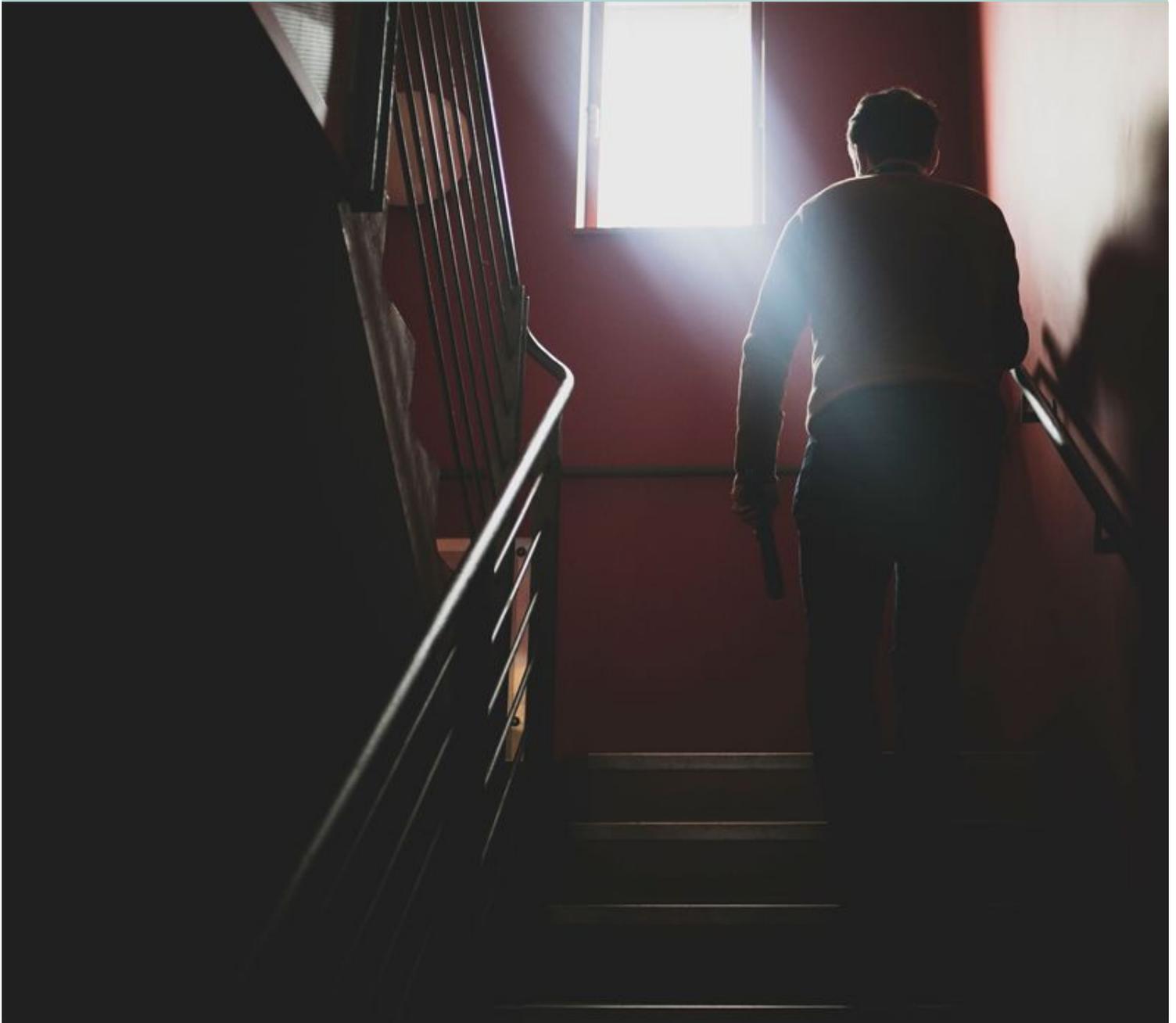


7. Future

Working together to build a strong local health economy that serves our community now and in the future.

Our commitments

- We will work in partnership with our local NHS partners to share information and best practice and develop collaborative approaches to decarbonising our health economy.
- We will create infrastructure, supply chain and logistics operations that are resilient to changes in the climate and extreme weather events.



Actions

KEY SUCCESS MEASURE FOR 2025: to work with our NHS partners across our STP to reduce emissions from the system in line with the targets set out in the Climate Change Act

ACTIONS to 2025

Working with our STP partners

- Lead on and progress an STP wide Sustainable Development Management Plan. This should include harmonised targets to 2025 and beyond, with a long term goal of reaching carbon neutrality or zero carbon.
- Develop mechanisms to collaborate with STP partners and stakeholders to share information, raise awareness and help agree, prioritise and deliver coordinated action on sustainability.
- Work in partnership with other NHS providers to identify, source and secure best value financing solutions for carbon reduction.
- Work through existing and new partnerships with social enterprises and voluntary groups to develop community-based sustainable healthcare projects and solutions. This could link in with our wider objectives around carbon neutrality.

Climate change adaptation

- Work with other Trusts within our STP area to undertake a Climate Change Risk Assessment to identify the likely impact of climate change to our staff, patients, carers, citizens and communities, infrastructure, supply chain and clinical services, including an analysis of the cost of this to the trust.
- Using this Risk Assessment, develop and deliver a Climate Change Adaptation Action Plan to reduce the risks associated with climate change and put in place plans to ensure continuation of care for our most vulnerable patients during heatwaves, floods and other extreme weather events. This should identify system-wide resilience strategies considered at an STP level and beyond.
- Ensure all new and existing premises are able to cope with increased frequency of heatwaves and floods and minimise the risk to staff, patients and visitors and weigh this as a key consideration when designing, planning or leasing new premises.
- Continue to provide advice to staff and patients on how to stay safe and well during heatwave and floods and other extreme weather events.
- Train our staff to recognise and respond to anticipated changes to the local climate and expected increases in the burden on the local health system.

Reaping the Benefits

By delivering on this SDMP to become a more sustainable healthcare provider, we are directly supporting our vision to deliver better health, for life. We can achieve immediate health and wellbeing benefits, significant cost savings and considerably reduce its impact on the environment – a true win-win-win.

Health and wellbeing benefits

Through this SDMP the Trust has the opportunity to achieve immediate health and wellbeing benefits, including:

- Reduced sickness absence and stress among our staff.
- Improved workforce health with an increased proportion participating in physical activity during the working day including travel to work.
- Greater ability to ensure appropriate care is available for vulnerable patients during heat waves, floods and other extreme weather events caused by climate change.

Value at Stake

By taking action to reduce our emissions as set out in this SDMP we can expect to realise significant CO₂ reductions and cost savings.

The estimated benefits of implementing this SDMP are summarised in the Value at Stake analysis shown Figures 7 & 8 on the following page. This illustrates the difference between doing nothing (a business-as-usual approach) and a reduced emissions scenario where the Trust takes an active approach to sustainability in line with this SDMP, reducing CO₂ emissions by 57% from a 2007 base year by 2025.

The Value at Stake analysis takes into account:

- Electricity and gas price inflation at 3.7% per year.
- Natural consumption growth of 0.7% per year.

On this basis the total cumulative benefits of implementing this SDMP at Imperial College Healthcare amount to:

- Cost savings of **£29 million** by 2025.
- A reduction of **27,500 tonnes** CO₂ by 2025.

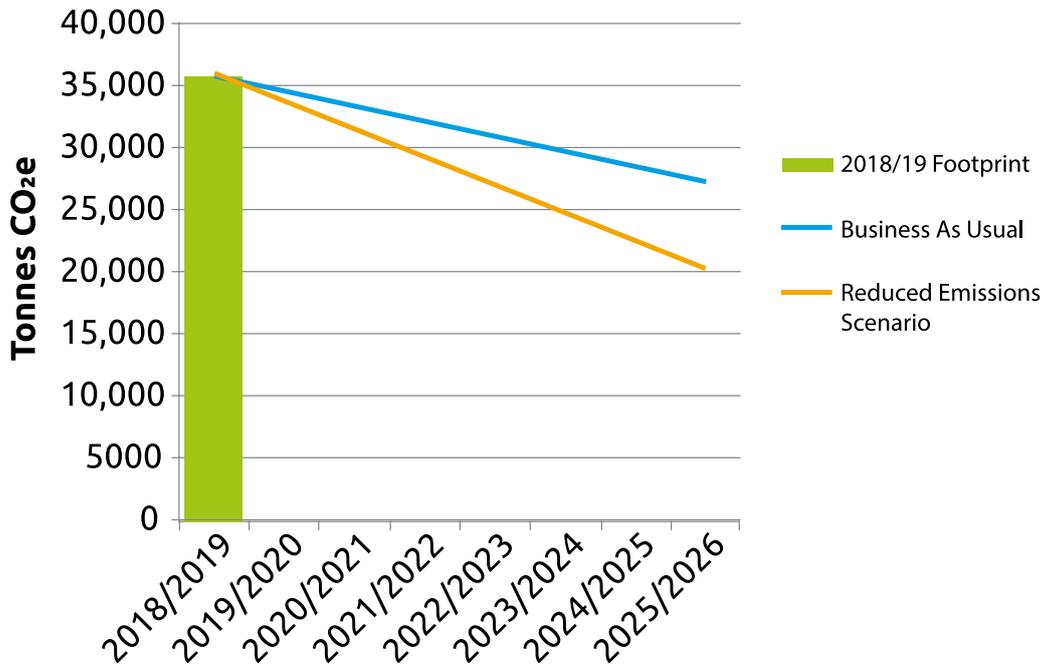


Figure 7: Imperial College Healthcare Value at Stake analysis – carbon emissions (CO₂e)

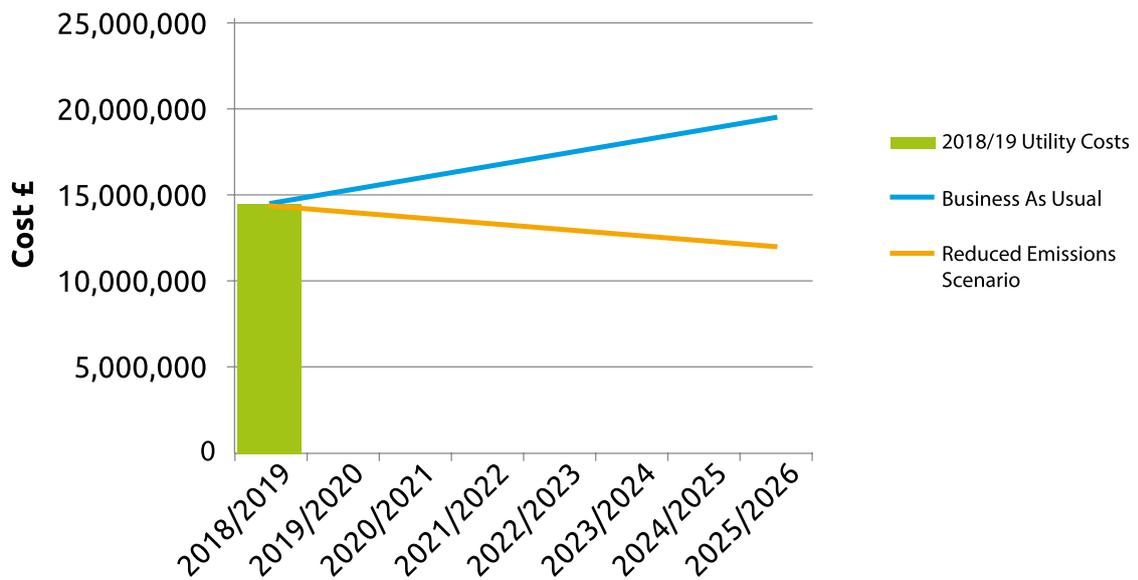


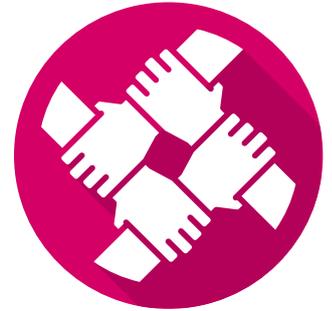
Figure 8: Imperial College Healthcare Value at Stake analysis – energy cost (£)

Appendix One: 12 month action plan

	Leadership	Buildings	Journeys
2025 goal	Sustainability principles embedded in core business and refreshed 2023 strategy	51% reduction in CO₂e from our buildings	51% reduction in all measurable travel CO₂e
Priority actions	<p>Appoint a Board Lead, Non-Executive Director Lead and Clinical Lead for sustainability.</p> <hr/> <p>Provide a dedicated resource to support the delivery of this SDMP, and consider best mechanism for resourcing within individual departments.</p> <hr/> <p>Form a Sustainability Steering Group to oversee the delivery of this SDMP.</p> <hr/> <p>Facilitate a discussion with the Board and key stakeholders to support integration of sustainable healthcare principles including through delivery of the Trust’s existing strategy.</p> <hr/> <p>Integrate sustainability into QI training programme and methodologies, and consider the potential to integrate sustainability as an aspect of QI roles.</p> <hr/> <p>Report to our Board on progress against this SDMP annually and to our and to a relevant committee on a regular basis.</p> <hr/> <p>Submit annual sustainability return to the SDU and publish a sustainability update in our Annual Report.</p>	<p>Continue the development of our Energy Performance Contract project in line with the carbon targets set out in this SDMP.</p> <hr/> <p>Commit to and develop a long term strategy for becoming a zero carbon NHS Trust.</p> <hr/> <p>Undertake sustainability surveys of our non-EPC sites/buildings to identify energy conservation measures.</p> <p>Develop a capital investment strategy for these opportunities.</p> <hr/> <p>Engage with CCS to look into the option of purchasing renewables backed/ generated electricity.</p> <hr/> <p>Ensure our increase in power requirement is minimised through procuring the most energy efficient equipment, moving to centralised power management and using thin client technology.</p> <hr/> <p>Ensure any changes to our property portfolio provide on-going improvements in working environment for staff and adequate facilities for break and rest periods.</p> <hr/> <p>Identify opportunities to use the green spaces across our estate to support staff wellbeing, patient recuperation and biodiversity and climate adaptation.</p>	<p>Sign up to the Clean Air Hospitals Framework to tackle local air pollution and support our wider patient care objectives.</p> <hr/> <p>Develop a programme to move towards a culture of flexible working. This should include consideration of staff engagement and technology requirements alongside a wider cultural transformation.</p> <hr/> <p>Introduce an electronic claims system to improve quality and consistency of data relating to travel claims.</p> <hr/> <p>Operate an annual staff travel survey and undertake an analysis of expenses data to gain a better understanding of staff travel patterns.</p> <hr/> <p>Continue to refurbish key meeting rooms across the Trust to enable videoconferencing and identify a preferred Trust supplier.</p> <hr/> <p>Continue to explore and develop the potential for Telehealth and Health Informatics technologies, enabling patients to receive consultations in their own home and provide a more flexible and convenient differently for a better working life.</p>

	Circular Economy	Culture	Wellbeing	Future
2025 goal	Measurable reduction in overall waste volumes, 60% offensive waste, 75% recycling and zero waste to landfill	100% of Trust engaged on sustainability with measurable benefits	Reduce staff sickness rate to 2.9% and improve staff survey results relating to wellbeing	Work with our STP partners to reduce emissions from the system to meet national targets
Priority actions	<p>Develop and implement a Waste Management Action Plan to support delivery against SDMP targets and actions.</p> <hr/> <p>Ensure all estates and facilities staff are appropriately trained, with responsibilities identified in the new FM contract.</p> <hr/> <p>Update waste signage across all Trust sites.</p> <hr/> <p>Work with catering providers to implement coffee cup recycling across all Trust sites.</p> <hr/> <p>Introduce KPIs for waste management, including site-by-site analysis.</p> <hr/> <p>Using procurement data, undertake a carbon "hotspots" analysis to help prioritise areas for improvement.</p> <hr/> <p>Introduce sustainability criteria and KPIs into key tenders and contracts.</p> <hr/> <p>Commit to and deliver against the NHS Plastics Pledge.</p>	<p>Develop and launch a staff engagement programme in line with the Staff Engagement Roadmap in Appendix 2 to raise awareness of this SDMP, communicate core messaging and drive positive action for sustainability at every level of the Trust.</p> <hr/> <p>Provide internal communication material to promote this SDMP including a section on our intranet.</p> <hr/> <p>Consider opportunities to include sustainability objectives in our staff induction.</p> <hr/> <p>Identify opportunities for an annual sustainability award.</p> <hr/> <p>Ensure all staff training and events are conducted in a low-carbon manner.</p> <hr/> <p>Participate in national sustainability campaigns such as NHS Sustainability Day and Clean Air.</p>	<p>Undertake an analysis of wellbeing data across the Trust to support the development of our Wellbeing Action Plan.</p> <hr/> <p>Undertake a review of our People Strategy 2019-2022 to identify sustainability opportunities under each of the six strategic themes.</p> <hr/> <p>Ensure that the commitments and goals set out in this SDMP are reflected in our new Wellbeing Plan and our subsequent annual Wellbeing Action Plans.</p> <hr/> <p>Promote the links between the environment, productivity and health and wellbeing. This should include information for all new starters.</p> <hr/> <p>Build on our successful Great Place to Work Week by integrating wider aspects of our sustainability programme.</p>	<p>Develop mechanisms to collaborate with STP partners and stakeholders to share information, raise awareness and help agree, prioritise and deliver coordinated action on sustainability.</p> <hr/> <p>Work with other Trusts within our STP area to undertake a Climate Change Risk Assessment to identify the likely impact of climate change to our patients and staff, infrastructure, supply chain and clinical services, including an analysis of the cost of this to the trust.</p>

Appendix Two: staff engagement roadmap



STAGE ONE: discovering what we need to know

Any engagement activity on sustainability must be based on an understanding of what staff know, what they need to know and where they get their information.

A range of research methods will allow us to benchmark views, capturing both qualitative and quantitative data. This should include:

- Telephone interviews with a broad mix of staff from

- different roles across the Trust
- Focus groups
- On line survey

The findings from this research will provide a benchmark on where staff are at with sustainable healthcare and will enable future engagement and behaviour change initiatives to be measured against this starting point.

STAGE TWO: establishing a presence for sustainability

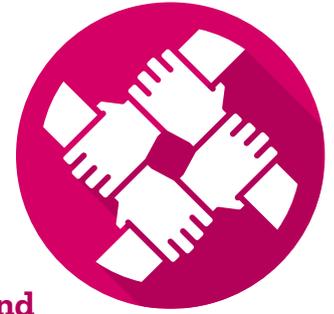
Key to engaging with our staff on sustainability is to demonstrate that as a Trust we take sustainability seriously, and clearly identifying where it sits within other core aspects of our operations.

To do this a regular flow of communications across a variety of channels is needed. This should include:

- A section on the intranet for sustainability to share progress, best practice and other information or guidance.
- Ambient communications materials such as floor, lift and stairwell stickers.

- A regular supply of internal communications using a variety of channels to update, motivate, inform and educate staff on sustainability in its broadest sense.

Communications should link sustainable behaviours to health and wellbeing, and use real staff stories to bring communications to life and encourage peer to peer influence on behaviour change.



STAGE THREE: embedding sustainable behaviours and thinking

To fully embed sustainability within the Trust a mixture of three approaches yields best results.

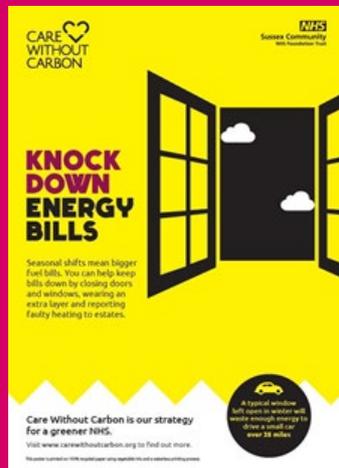
1. Coordinated staff engagement campaign

Use direct marketing and communications activity to share key messages and drive behaviour change.

EXAMPLE: BACK TO BASICS

The Care Without Carbon team at SCFT developed a 'Back to Basics' campaign which looks at the core environment behaviours needed to tackle reducing impact on the

environment. The campaign covered both water and energy use, with posters displayed at the point of action, so for example the 'don't be a drip' poster was in place next to taps.





EXAMPLE: DARE TO CARE

Another example is the integrated sustainability engagement programme called Dare to Care which is used by several Trusts (including acute, community and mental health) to support the wider SDMP work.

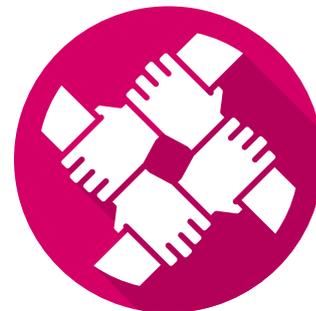
Dare to Care offers staff a range of pledges they can take that all help to reduce their impact on the environment and/or boost wellbeing and save money. The

pledges are developed with staff input and are changed regularly to revive engagement over time.

The programme of engagement is designed to promote small actions that add up to big change, and all pledges are recorded on the Care Without Carbon website (www.carewithoutcarbon.org) to provide a sense of scale and impact.

The website also features blog posts from staff to share ideas, stories and drive engagement.





2. Champions programme

A sustainability champions programme is a great way to engage staff at a deeper level on sustainability, empowering them to support work to become more sustainable and to act as on the ground advocates and change leaders.

EXAMPLE: CWC ENVOYS

At Sussex Community and Sussex Partnership NHS Foundation Trusts, the Care Without Carbon team established a CWC Envoy Programme.

The programme was open to all staff, with Envoys required to represent sustainability each month as an agenda item at the team meetings. Each month is themed around a key aspect of sustainability and Envoys are provided with a toolkit to support them in discussing the topic at their team meeting.

In addition to the monthly themes, Envoys are encouraged to bring forward any particular projects they may want to deliver with a sustainability focus. The Quality Improvement team are brought in to offer support on this and to ensure the work meets Trust criteria for change and improvement.

Envoys meet regularly via conference calls to share ideas, challenges and best practice. This means it works well over multiple sites and to fit in with busy schedules.

3. Clearly communicated Board level support

Ensuring visible Board level support to drive change throughout the Trust is key to delivery against this SDMP. This can be achieved through:

- Identifying at least one Board Lead for sustainability - or alternatively multiple leads for different areas.
- Referencing sustainability in internal communications and messages from senior members of the Trust, for example the Chief Executive Officer and Director of Operational Performance, Director of Transformation and Director of Strategy, Research and Innovation.
- Embedding principles of sustainability into key Trust strategies.

STAGE FOUR: review and adapt

Change is a long term programme of activity and won't happen overnight. Any engagement planning should plan to cover several years and include annual review periods to ensure messaging is still relevant and landing well with staff.



Imperial College Healthcare
NHS Trust



For further information please contact:
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Imperial College Healthcare NHS Trust
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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Month 10 integrated quality and performance report	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input checked="" type="checkbox"/> Discussion <input type="checkbox"/> Information
Date of Meeting: Wednesday 25 March 2020	Item 10, report no. 07
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development) Claire Hook (Director of Operational Performance)	Author: Submitted by Performance Support Team
Summary: This is the integrated quality and performance report for data published at month 10 (January 2020). Contents: <ul style="list-style-type: none"> • Summary report of key headlines • Indicator scorecard • Appendix 1: Additional slides by exception (for information) 	
Recommendations: The Board is asked to note the contents of this report.	
This January 2020 performance scorecard and reports have been discussed at: Executive Operational Performance Committee Executive Quality Committee Executive Finance Committee Board Quality Committee Finance, Investment and Operations Committee	
Quality impact: The delivery of the full integrated quality and performance report will support the Trust to more effectively monitor delivery against internal and external targets and service deliverables. All CQC domains are impacted by the paper.	
Financial impact: The financial impact of this proposal as presented in the paper enclosed: Has no financial impact.	

<p>Risk impact and Board Assurance Framework (BAF) reference:</p> <ul style="list-style-type: none"> - 2472: Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards - 2477: Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues - 2480: Patient safety risk due to inconsistent provision of cleaning services across the Trust - 2485: Failure of estates critical equipment and facilities - 2487: Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) - 2942: Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines - 2937: Failure to consistently achieve timely elective (RTT) care - 2938: Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards - 2943: Failure to maintain non elective flow - 2944: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas - 2946: Failure to provide timely access to critical care services - 1660: Risk of poor waiting list data quality
<p>Workforce impact (including training and education implications): None</p>
<p>Has an Equality Impact Assessment been carried out or have protected groups been considered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable</p> <p>If yes, are further actions required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>What impact will this have on the wider health economy, patients and the public? Comprehensive performance and quality reporting is essential to ensure standards are met which benefits patients. The report is aligned with CQC domains to ensure the Trust has visibility of its compliance with NHS wide standards.</p>
<p>The report content respects the rights, values and commitments within the NHS Constitution <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Trust strategic goals supported by this paper:</p> <ul style="list-style-type: none"> ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
<p>Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, why?.....</p>

Integrated quality and performance report

1. Introduction

- 1.1. The Board are asked to consider the integrated quality and performance report and the key headlines relating to performance as at January 2020 (month 10).
- 1.2. The indicator scorecard and this summary report highlights where performance is above target, or within tolerance, and where performance did not meet the agreed target / threshold.

2. Key headlines

The key highlights from the January 2020 performance scorecard are provided below.

Quality

- 2.1. The incident reporting rate was above target and the overall number of incidents reported has continued to improve. The number of transport related incidents has also reduced. In terms of overall harm profile, the percentage of incidents causing moderate and above harm is within target for the financial year to date.
- 2.2. The Never Event declared in January 2020 under the category 'misplaced oro-gastric tube' is under investigation; initial review highlighted human error where the incorrect chest x-ray was reviewed when the position was checked.
- 2.3. The Trust's compliance with the duty of candour increased to 97% (financial year to date). An escalation process has been shared with divisions which will support us to make continued improvements. A review of our approach to the duty of candour will commence in April 2020 and a report will be presented to the June 2020 quality committee.
- 2.4. In January 2020,
 - There have been 90 cases of hospital-associated *C. difficile* in total so far this year, and 10 occurred in January 2020. We are now over our target of 77 cases for the whole financial year. Of the 90 cases, only one case in October 2019 was associated with a lapse in care (due to cross transmission).
 - 6 cases of Trust-attributable *E.coli* cases were reported in January 2020 and we are on track to meet our 10% reduction target for 2019/20.
 - There was 1 case of CPE BSI reported in January 2020, bringing the total to 7 cases so far this financial year, compared to 6 this time last year.
- 2.5. Data for January 2020 shows that 88% of patients received antibiotics within 1 hour of confirmed sepsis diagnosis, below our 90% target. The performance remains within

tolerance but we will monitor compliance over the coming months via our deteriorating patient safety stream. Exception reporting will be provided with a formal improvement plan, should performance not improve.

- 2.6. The approach to conducting mortality reviews has been amended to refocus on the quality of care and treatment provided to the patient.
- 2.7. Vacancy rates have continued to improve and remain within the 10% target.
- 2.8. All Friends and Family Test scores have remained within tolerances across the care settings, with the exception of patient transport where feedback is still quite limited.

Operational performance

- 2.9. In January 2020, two patients had been waiting for more than 52 weeks for treatment. The overall size of the referral to treatment waiting list size appears stable and is meeting the trajectory. The diagnostic target was met following the use of a number of additional due to sustained increases in demand.
- 2.10. A final report on the review of the NHS Access Standards, including the outcomes on the national pilot of the proposed Urgent and Emergency Care metrics, is expected in Spring 2020.

3. Additional information

- 3.1. Exception slides are provided for information in appendix 1, covering the following scorecard metrics:
 - 1) Never Events
 - 2) Carbapenemase Producing Enterobacteriaceae (CPE)
 - 3) Safeguarding in children training
 - 4) Cleanliness audits
 - 5) National clinical audits
 - 6) Mortality reviews
 - 7) Patient transport - FFT
 - 8) Mixed sex accommodation
 - 9) RTT patients waiting 18 weeks and under
 - 10) RTT patients waiting more than 52 weeks
 - 11) Theatre utilisation
 - 12) Cancer waiting times
 - 13) A&E patients waiting more than 12 hours from decision to admit
 - 14) Ambulance handovers (30 minute delays)
 - 15) Long length of stay
 - 16) Data Quality Error Rates – Referral to Treatment

4. Recommendation

The Board is asked to note the contents of the integrated performance report for month 10.

Integrated Quality and Performance Scorecard

Same period
last yearLatest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
FYTD = Financial Year to Date											
Safe											
Patient safety - incident reporting											
Serious incidents	-	Jan-20		5	44	22	15	25	22	18	34
Incidents - moderate harm (FYTD)	<1.68%	Jan-20		1.25%	1.20%	1.17%	1.29%	1.39%	1.44%	1.47%	1.52%
Incidents - severe/major harm (FYTD)	<0.23%	Jan-20		0.04%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%
Incidents - extreme harm/death (FYTD)	<0.09%	Jan-20		0.04%	0.08%	0.07%	0.07%	0.07%	0.07%	0.09%	0.08%
Incident reporting rate (per 1,000 beds)	>=50.38	Jan-20		49.92	57.10	47.73	51.04	54.26	54.19	47.35	56.24
Never events	0	Jan-20		2	0	0	0	0	2	0	1
PSAs open and overdue (FYTD)	0	Jan-20		-	0	0	0	0	0	0	0
Incidents with DoC completed	100%	Dec-19		-	94.2%	95.8%	96.1%	96.9%	94.9%	92.0%	96.8%
Infection prevention and control											
Trust-attributed MRSA BSI (FYTD)	0	Jan-20		3	3	3	3	3	3	3	3
Trust-attributed C. difficile (FYTD)	77	Jan-20	62	-	37	47	53	63	70	80	92
Trust-attributed C. difficile (lapses in care) (FYTD)	0	Jan-20		-	0	0	0	1	1	1	1
E. coli BSI (FYTD)	75	Jan-20	67	74	27	30	35	45	54	61	67
CPE BSI (FYTD)	0	Jan-20		6	3	6	6	6	6	6	7
VTE											
VTE risk assessment	>=95%	Jan-20		93.8%	97.3%	97.4%	98.5%	97.9%	97.6%	97.2%	97.5%

Integrated Quality and Performance Scorecard

Same period
last year

Latest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
FYTD = Financial Year to Date											
Safe											
Flu											
Flu vaccination for frontline healthcare workers	>=75%	Jan-20		53.3%	-	-	-	34.0%	55.8%	61.5%	62.1%
Sepsis											
Sepsis - Antibiotics	>=90%	Jan-20		92.8%	89.7%	89.4%	90.7%	88.6%	90.5%	89.8%	87.7%
Maternity standards											
Puerperal sepsis	<=1.5%	Jan-20		0.4%	1.1%	1.3%	0.9%	1.1%	1.0%	1.0%	1.2%
Safe staffing											
Safe staffing - registered nurses	>=90%	Jan-20		96.7%	97.3%	97.1%	97.2%	97.0%	97.0%	96.7%	97.2%
Safe staffing - care staff	>=85%	Jan-20		94.8%	96.9%	96.6%	96.3%	96.3%	95.4%	95.0%	95.7%
Workforce and people											
Core skills training	>=90%	Jan-20		90.5%	92.5%	93.5%	93.8%	93.8%	94.3%	94.3%	93.4%
Safeguarding children training (level 3)	>=90%	Jan-20		83.3%	88.5%	87.0%	86.0%	85.0%	85.0%	89.0%	88.0%
Vacancy rate - Trust	<10%	Jan-20		13.3%	12.0%	11.7%	11.1%	10.3%	9.7%	10.0%	9.7%
Estates and Facilities											
Cleanliness audit scores (very high risk)	>=98%	Jan-20		80.0%	95.0%	92.0%	88.5%	92.1%	90.2%	89.9%	89.8%
Cleanliness audit scores (high risk)	>=95%	Jan-20		89.0%	96.0%	80.0%	93.1%	91.1%	94.1%	93.9%	96.1%
Reactive maintenance	>=70%	Jan-20		26.0%	61.6%	61.4%	67.0%	57.0%	65.0%	72.0%	70.0%

Integrated Quality and Performance Scorecard

Same period
last yearLatest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
FYTD = Financial Year to Date											
Effective											
Mortality indicators											
HSMR: Trust ranking	top 5 lowest risk	Oct-19		17th Lowest	9th Lowest	5th Lowest	Lowest	5th Lowest	24th Lowest	24th Lowest	Lowest
HSMR ratio	<100	Oct-19		74.0	72.0	56.0	60.0	55.0	72.0	79.0	60.0
SHMI: Trust ranking	top 5 lowest risk	Aug-19		4th Lowest	Lowest	Lowest	Lowest	Lowest	Lowest	Lowest	Lowest
SHMI ratio		Aug-19		66.8	70.5	70.7	70.3	70.3	69.7	67.8	68.7
Mortality reviews (at 13/02/2020)											
Total number of deaths	-	Dec-19		145	128	119	160	162	138	147	151
Overall Quality Of Care (Very Poor/Poor) (FYTD)	0	Dec-19		-	-	-	-	-	-	-	0
SJR's not completed within 30 days (FYTD)	0%	Dec-19		-	63.0%	63.1%	62.6%	60.9%	60.4%	65.1%	64.9%
Readmissions (unplanned)											
under 15 yr olds	<9.33%	Jul-19		3.8%	4.5%	4.1%	4.4%	4.6%	5.1%	4.3%	5.1%
over 15 yr olds	<8.09%	Jul-19		7.0%	6.5%	6.9%	7.1%	8.1%	7.1%	7.7%	7.7%
National Clinical Audits											
Participation in relevant NCAs (FYTD)	100%	Oct-19		88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
High risk/significant risk audits with action plan (FYTD)	100%	Oct-19		100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Review process not completed within 90 days	0	Oct-19		6	1	7	11	18	19	30	34
Clinical trials											
Recruitment of 1st patient within 70 days	>=90%	Qtr 3 19/20		Qtr 4 17/18 67.6%	Qtr 1 18/19 85.1%	Qtr 2 18/19 95.7%	Qtr 3 18/19 93.9%	Qtr 4 18/19 96.0%	Qtr 1 19/20 96.3%	Qtr 2 19/20 100.0%	Qtr 3 19/20 92.8%

Integrated Quality and Performance Scorecard

Same period
last year

Latest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
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FYTD = Financial Year to Date

Caring

Friends and Family

A&E - % recommended	>=94%	Jan-20		95.4%	92.5%	93.5%	94.4%	94.4%	92.3%	92.2%	93.0%
A&E - % response rate	>=15%	Jan-20		12.2%	14.6%	17.3%	16.1%	20.0%	18.6%	18.8%	14.1%
Inpatients - % recommended	>=94%	Jan-20		97.7%	97.2%	97.3%	97.3%	96.9%	97.8%	96.9%	96.9%
Outpatients - % recommended	>=94%	Jan-20		93.8%	94.5%	94.0%	93.9%	94.1%	94.1%	95.2%	94.6%
Maternity - % recommended	>=94%	Jan-20		93.6%	92.5%	93.4%	95.2%	94.7%	91.4%	90.2%	92.7%
Patient Transport - % recommended	>=90%	Jan-20		92.4%	50.0%	48.3%	44.4%	49.5%	68.2%	57.1%	68.0%

Mixed sex accommodation

Mixed-sex accommodation breaches	0	Jan-20		50	41	15	28	45	42	47	47
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Well led

Workforce and people

Voluntary staff turnover rate (12m rolling)	<12%	Jan-20		11.7%	11.8%	11.7%	11.8%	11.8%	11.8%	11.8%	12.0%
Sickness absence rate (12m rolling)	<=3%	Jan-20		3.13%	3.20%	3.18%	3.18%	3.24%	3.26%	3.29%	3.29%
Doctor appraisal rate	>=95%	Jan-20		91.7%	93.0%	93.4%	94.0%	94.8%	95.1%	95.3%	95.3%
Consultant job planning completion rate	>=95%	Jan-20		-	91.3%	91.6%	91.6%	91.6%	91.6%	55.1%	61.5%

Integrated Quality and Performance Scorecard

Same period
last yearLatest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	
FYTD = Financial Year to Date												
Responsive Data reliability rating												
Referral to treatment (elective care)												
RTT patients waiting < 18 weeks	6%	>=92%	Jan-20	83.9%	84.6%	82.8%	83.6%	81.8%	81.4%	80.4%	79.5%	
RTT waiting list size		63,099	Jan-20	63,100	64,660	63,098	62,918	62,664	60,992	63,036	62,608	62,583
Long waiters												
RTT patients waiting > 52 weeks	4%	0	Jan-20		44	0	2	3	2	4	8	2
Cancer waiting times												
Two Week Wait		>=93%	Dec-19		94.2%	91.0%	85.8%	82.9%	84.5%	89.1%	91.7%	89.6%
62 Day Screening Standard	5%	>=90%	Dec-19		53.5%	80.8%	73.9%	77.3%	92.0%	81.5%	82.0%	76.1%
62 Day Wait (start of treatment)		>=85%	Dec-19	85.0%	86.8%	86.7%	87.3%	86.9%	86.3%	83.7%	87.4%	89.1%
Theatre utilisation												
Theatre touchtime utilisation		>=85%	Jan-20	80.3%	75.1%	80.4%	82.4%	82.2%	79.5%	78.1%	74.2%	75.0%
Critical care												
Critical care patients admitted within 4 hours		100%	Jan-20		92.5%	95.0%	94.4%	94.6%	96.4%	93.6%	96.4%	93.6%
Urgent & Emergency Care (UEC)												
A&E patients waiting > 12 hours from DTA	1%	0	Jan-20		10	17	8	7	8	5	11	10
A&E ambulance handover delays 30 minutes		100%	Jan-20	100%	85.0%	90.6%	90.6%	91.4%	92.7%	92.7%	89.3%	89.5%
Length of stay												
Patients with LoS >= 21 days	3%	tbc	Jan-20		244	218	212	212	208	206	233	224
Discharges before noon		>=33%	Jan-20		15.4%	16.0%	16.3%	16.1%	16.0%	16.2%	15.0%	16.1%
Diagnostics												
Diagnostic test waits > 6 weeks	0.4%	<1%	Jan-20		0.78%	0.90%	1.04%	0.50%	0.69%	1.15%	1.67%	0.79%

Key to data reliability scores:

Data reliability scores are currently provided for the above RTT, Cancer, Emergency care, Diagnostics and Long stay patient datasets

Above 5% error rate to inform a **Red** data quality rating.5% error rate or below to inform a **Green** data quality rating.

Integrated Quality and Performance Scorecard

Same period
last year

Latest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
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FYTD = Financial Year to Date

Responsive

Outpatients

DNA	<10%	Jan-20		11.1%	10.7%	11.1%	10.8%	10.7%	10.1%	10.7%	10.3%
HICs (Appt moved to a later date)	<7%	Jan-20	7.0%	6.9%	7.2%	7.9%	7.4%	7.3%	6.3%	7.7%	6.9%

Complaints management

Complaints - formal	<90	Jan-20		89	136	87	98	100	83	87	80
Complaints – average days to respond	40 days	Jan-20		28.6	32.4	32.7	36.3	35.7	33.3	32.2	34.0
Complaints - patient satisfaction with handling	>=70%	Jan-20		-	81.0%	85.0%	82.0%	82.0%	72.0%	78.0%	73.0%

Patient transport

All Journeys: Collection Time (60 Mins)	>85%	Jan-20		94.2%	86.4%	77.6%	68.7%	86.2%	74.7%	89.3%	93.3%
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Data quality

Data Quality Maturity Index	>98%	Oct-19	95%	95.2%	99.3%	99.3%	99.3%	99.3%	99.2%	99.3%	99.3%
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Integrated Quality and Performance Scorecard

Same period
last yearLatest
reported
performance

Indicator	Overall target	Latest Period	Trajectory	Jan-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
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FYTD = Financial Year to Date

Use Of Resources

Finance KPIs

Monthly finance score (1-4)	-	Jan-20		3	3	3	3	3	3	3	3
In month Position	-	Jan-20		-3.61	0.00	0.12	-0.05	3.80	-1.60	-2.19	0.00
YTD Position £m	-	Jan-20		-3.90	0.97	1.09	1.03	4.80	3.19	1.01	1.01
Annual forecast variance to plan	-	Jan-20		-4.00	-18.11	-11.34	-9.14	-5.02	-6.51	-3.52	-2.62
Agency staffing	-	Jan-20		4.2%	3.2%	3.1%	2.9%	2.8%	2.8%	2.7%	2.6%
CIP (FYTD)	-	Jan-20		77.5%	64.6%	66.0%	74.1%	73.5%	74.8%	75.0%	74.4%

Appendix 1: Month 10 integrated performance report - exception slides

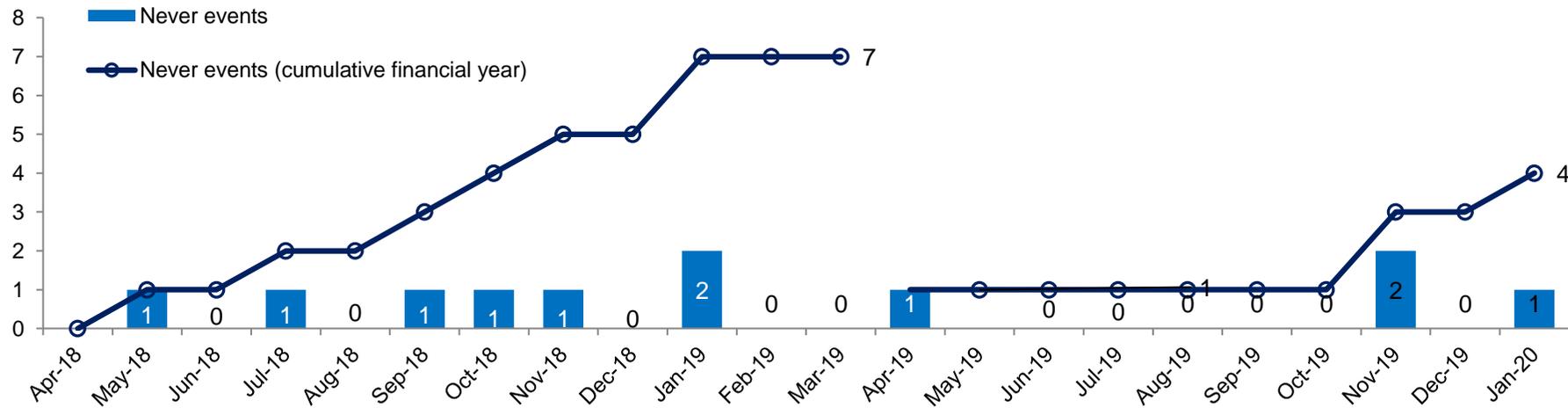
Report

1. Never Events
2. CPE
3. Safeguarding in children training
4. Cleanliness audits
5. National clinical audits
6. Mortality reviews
7. Patient transport - FFT
8. Mixed sex accommodation
9. RTT patients waiting 18 weeks and under
10. RTT patients waiting more than 52 weeks
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14. Ambulance handovers (30 minute delays)
15. Long length of stay
16. Data Quality Error Rates – Referral to Treatment

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 Never Events	0	December 2019: 0 January 2020: 1	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance

Never events 2018/19 and 2019/20 year to date

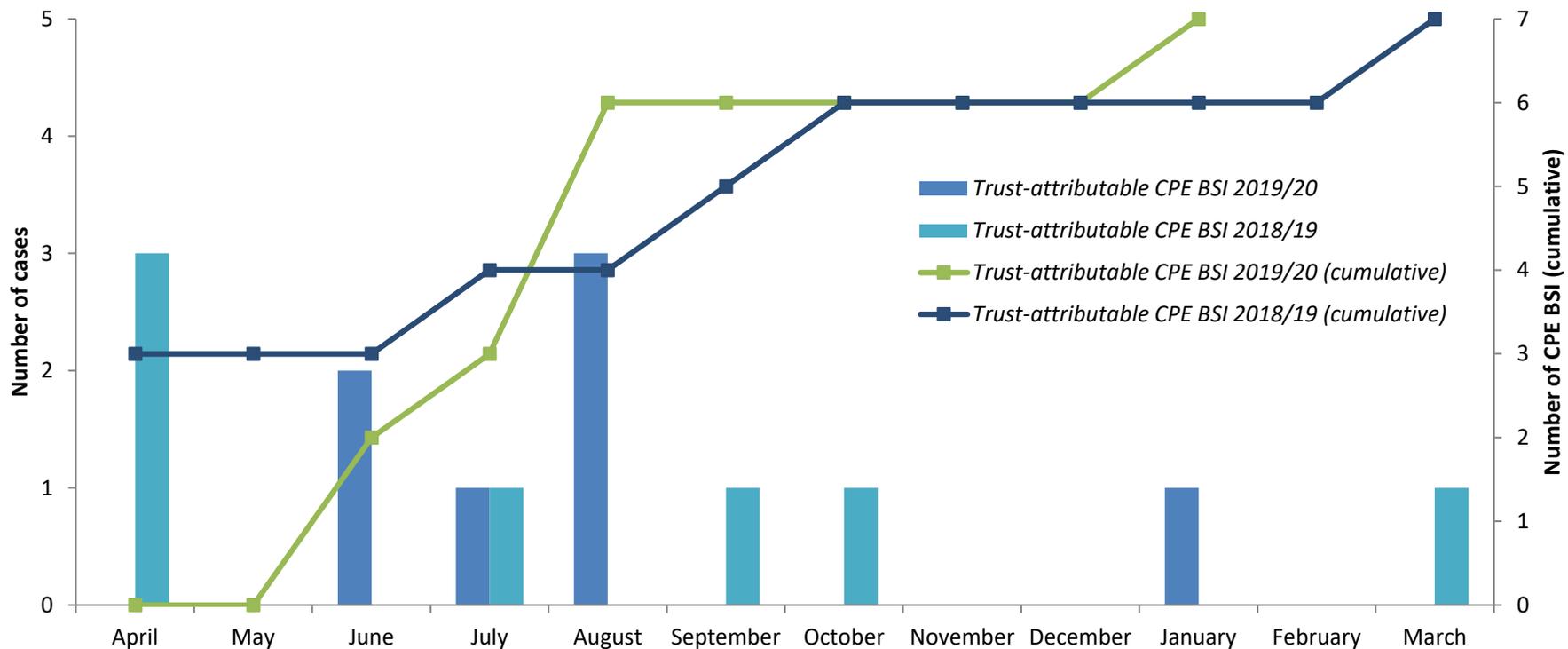


Latest Performance

- There were 0 Never Events in December 2019.
- A Never Event was declared in January 2020 in Endocrinology (MIC Division) which was a ‘Mis-placed Oro-nasogastric tube’. A nasogastric tube was re-inserted into a patient. A chest x-ray was carried out and the nurse was advised the tube was in the correct place so the feed was re-started. In response to the patient coughing, the nurse stopped the feed shortly after starting it. The chest x-ray was reviewed and the Dr advised that the tube was not in the correct position, the patient was given approximately 200ml of water and 150ml of feed.
- Initial findings highlight that a single human error contributed to the incident as an old x-ray was reviewed taken when the first feeding tube was inserted.
- Immediate actions included reminding all staff that interpret x-rays to always check the most recent film is being reviewed.
- This Never Event is under investigation and a report will be presented to the Medical Directors Review Pane on 06/03/20
- Four never events have occurred so far in 2019/20; two retained foreign bodies (May 2019, November 2019), one wrong site surgery (November 2019), and this Mis-placed oro-nasogastric tube (January 2019). A trust wide action plan is in place focusing on invasive procedure improvement which reports to Executive Quality Committee and Board Quality Committee.

Safe - CPE

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have no healthcare-associated Bloodstream infections (BSIs) caused by Carbapenemase Producing Enterobacteriaceae (CPE)	0	0 – Dec 2019 1 – Jan 2020 YTD = 7	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	There has been one Trust-attributable CPE BSI case in Jan 2020, none in Dec 2019. There have been a total of 7 cases so far in 2019/20 compared to 6 this time during 2018/19.
Return to target / trajectory	Target for CPE BSI is zero, therefore no return to target for 2019/20.

Safe - CPE

Key issues

There has been one Trust-attributable CPE BSI case in January 2020.

70 year old renal transplant patient, known carrier of CPE (*K. pneumoniae* OXA-48) who developed BSI. Urosepsis confirmed as source. Remains an inpatient on treatment.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Case review of BSIs to identify learning	Eimear Brannigan, Deputy DIPC	On-going action	Case reviews for 2019/20 will be collated to identify learning. However, the case reviews initially indicate limited opportunity for prevention in these cases other than prevention of CPE acquisition, by a focus on reducing carbapenem use and improving IPC practice especially hand hygiene.
Develop and launch Cerner CPE screening tool to promote and support implementation of CPE screening.	Jon Otter, General Manager, IPC	Timeline TBD	An agreement has been reached between ICHT and Chelsea and Westminster Hospital NHS Trust to use the same tool for both organisations. Once a timeline has been provided, communications will be sent to staff to promote the use of the tool.

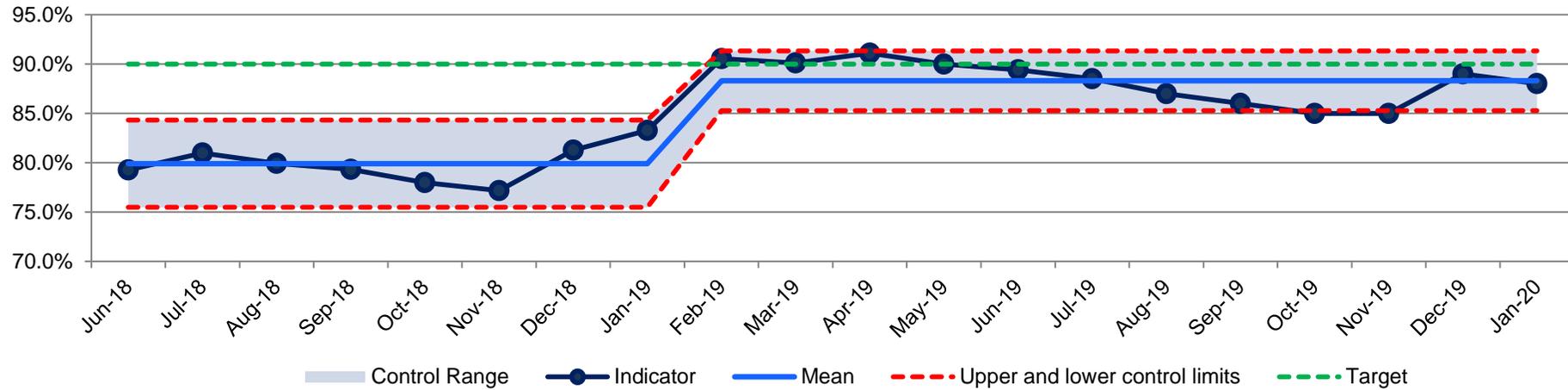
Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2487 - Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae))

Safe – Safeguarding in children training (level 3)

Indicator	Target	Latest data	Executive lead	Report author(s)
Proportion of eligible staff that are compliant with level 3 safeguarding children training	90% or greater	January 2020 compliance was 88%	Janice Sigsworth (Director of Nursing)	Guy Young (Head of Patient Experience)

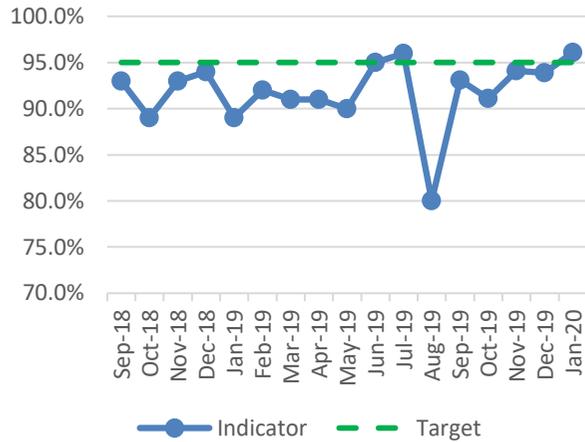
Safeguarding children training (level 3)



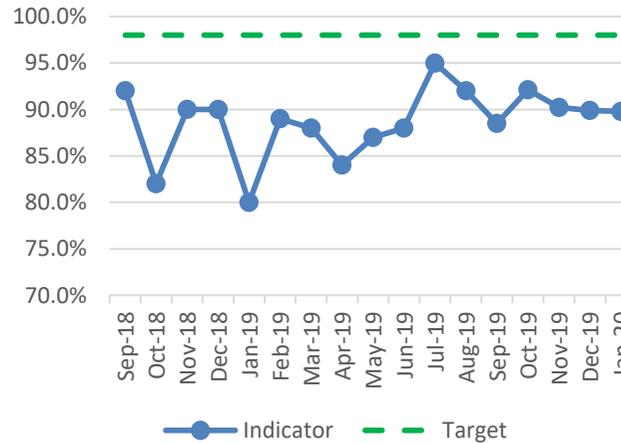
Issues and root cause	<ul style="list-style-type: none"> There has been an overall improvement in compliance in December and January and we remain on track to meet the 90% target by end of financial year.
Key updates	<ul style="list-style-type: none"> Level 3 children’s safeguarding training is a classroom based half day of training. Staff are expected to book onto training via their <i>Learn</i> account. At 31 January 2020, 200 staff were showing as non-compliant; the vast majority being new starters. At the time of writing (27.09) 88 staff had completed training in February with another 80 booked so far on training during March. In theory this should take the level above 90% but doesn’t factor in February new starters. However, three sessions per month have been arranged through to the end of June, so there is plenty of space available to meet the demand. <p><i>* LEARN is the Trust’s integrated learning management system which will enables our staff to complete online learning and book courses.</i></p>

Safe – Cleanliness audit scores				
Indicator	Target	Latest data	Executive lead	Report author(s)
Cleanliness audit scores	98% or greater (very high risk); 95% (high risk)	January 2020 compliance was 90% (very high risk) and 96% (high risk)	Janice Sigsworth (Director of Nursing)	Hugh Gostling

Cleanliness audit scores (high risk patient areas)



Cleanliness audit scores (very high risk patient areas)



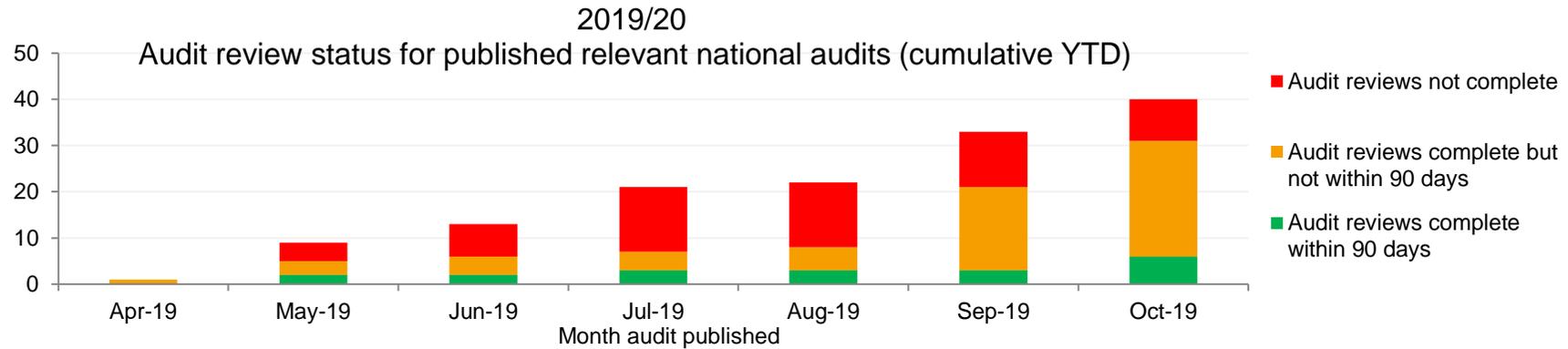
Latest performance

- High risk patient areas
- The target was met. 440 audits were undertaken (411 passed and 29 failed, 12 of the failures were within 2% of target).
- Very high risk patient areas
- Performance remained below target. 118 audits were undertaken (94 passed and 24 failed, 12 of the failures were within 2% of target).

Issues and root cause	<p>The main issue is inconsistent cleaning provision across the trust estate a combination of domestic services, training, equipment and access.</p> <p>Regular cleaning audits are performed as part of a scheduled regime of cleaning and auditing of standards.</p>
Key updates	<ul style="list-style-type: none"> ➤ Close monitoring of the cleaning service continues to be undertaken and issues escalated to the contractor, via weekly monitoring meetings, improvement remains localised, this process will continue to the end of the current contract on 31 March 2020. Lack of staff has been an increasing issue as staff have been using up their remaining annual leave before the contract ends and they are transferred . ➤ Cleaning is closely monitored through the corporate risk register <i>ID 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust.</i> ➤ Risk reduction plan for higher risk areas with low cleaning scores being developed.

Effective – National clinical audit

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits Number of audits that have not completed the review process within 90 days	100% participation 34 – YTD (25 complete but not within 90 days, 9 outstanding)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor



Latest performance	<p>Data is reported on a monthly basis, but the data presented here is three months in arrears to allow time to go through the Trust internal review process.</p> <p>40 national audit reports have been published so far this financial year, all of which were relevant to the Trust. Our participation rate for national clinical audits published is currently 100% (40/40 audits). *The participation rate has changed since previous exception slides as it has been agreed to remove audits from the British Association of Urological Surgeons (BAUS) from the scorecard. Five BAUS audits have been published since April 2019. Assurance for BAUS is provided by the division through an alternative arrangement agreed at Executive Quality Committee – these audits are outstanding.</p> <p>Divisional reviews were completed within 90 days for six of the national audits, published this year. Reviews were completed for 25 of them outside of the 90 day deadline. Nine reviews remain outstanding which is an improved position compared to previous months.</p> <p>There has been 1 audit (National Clinical Audit of Specialist Rehabilitation following Major Injury) from SCCS Division identified as Significant Risk so far, the risk is associated with issues across the system regarding specialist neurological, spinal and MSK rehabilitation beds affecting flow. An action plan is in place and updates will be presented to Q&S subgroup in April 2020.</p>
Return to target / trajectory	Progress is tracked weekly at the MD incident panel.

Effective – National clinical audit

Issues and root causes There are issues with the timely review and risk assessment of audit reports by divisions within the internally set target of 90 days. So far this year, 15% of reviews were completed within 90 days, compared to 65% at the end of 2018/19. The 9 outstanding reviews have been escalated to the divisions through the Clinical Audit and Effectiveness Group and the Medical Director's Incident Review Panel. These are expected to be completed by the end of Q4.

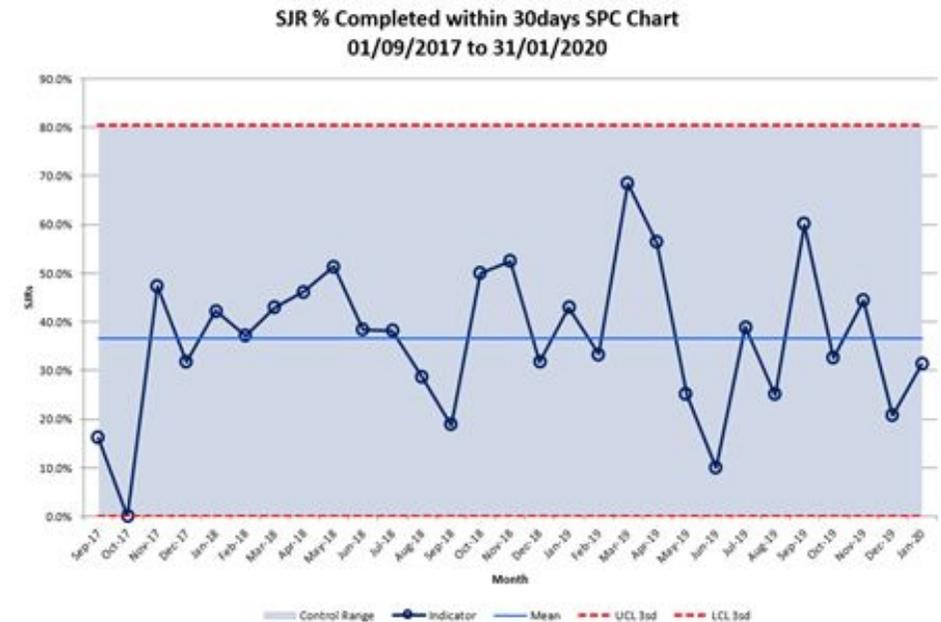
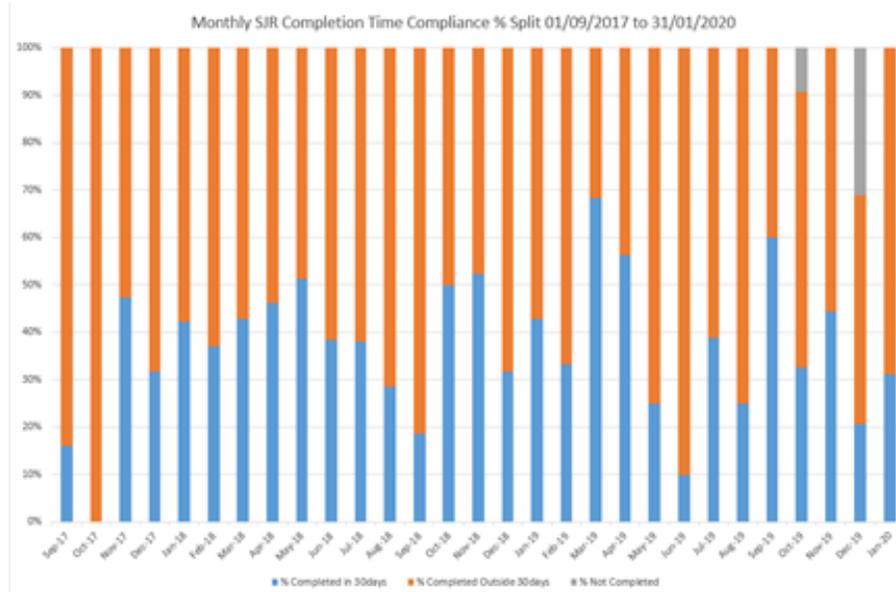
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Overdue audits escalated at the weekly Friday MD panel for review.	Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings. Escalation in place for a number of outstanding audits with dates of completion agreed for all.
National Clinical Audit of Specialist Rehabilitation following Major Injury	Davina Richardson	April – 20	Action plan update due to the Quality & Safety sub group.

Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2136) Failure to deliver the Trust's requirements as part of the national clinical audit programme)

Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	November 2019: 9 requested, 7 complete. December 2019: 29 requested, 20 complete.	Julian Redhead, Medical Director	Trish Bourke, Mortality Audit Manager



Latest performance	<ul style="list-style-type: none"> The graph above shows the percentage of structured judgement reviews (SJRs) completed by month. We continue to have an issue with meeting our performance target for the completion of SJRs within 30 days of request; our YTD performance remains at 65% of reviews being completed late.
Return to target / trajectory	<p>We are continuing to recruit additional SJR reviewers in order to deliver more capacity. SJRs are being reassigned where there is a delay in order to deliver timely outcomes. A full review of our approach and methodology to undertaking mortality reviews has been completed and we are no longer reporting 'Avoidable Deaths'. We intend to commission the Royal College of Physicians (London) to support us to identify ways in which we may be able to improve our performance and processes associated with learning from deaths.</p>

Effective – Mortality reviews

Issues and root causes

We continue to have an issue with meeting our performance target for the completion of SJRs within 30 days of request, with 65% not completed within the timeframe YTD. This is due to the allocated reviewer not completing it within the allotted timeframe, usually because of capacity issues.

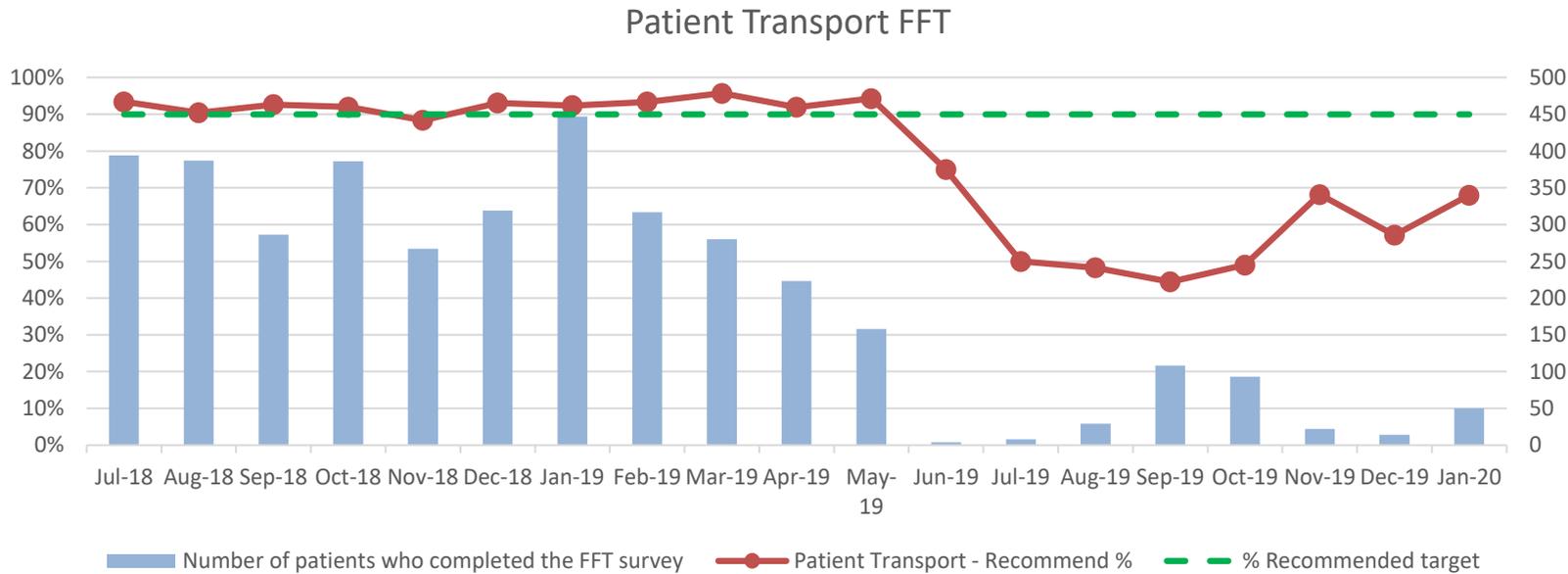
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	General Manager, MDO	May 2020	Additional reviewers have been identified, we are currently working with the Royal College of Physicians (London) in order to design bespoke training for new and current reviewers. We expect new reviewers to be in place by May 2020.
Diagnostic work with Royal College of Physicians	General Manager, MDO	May 2020	We intend to commission the Royal College of Physicians to undertake a review and diagnostic on our learning from deaths processes in order to identify areas in which we may be able to work more efficiently – learning from other organisations.

Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2439 Learning from Deaths)

Caring – Patient Transport Friends and Family Test - % Recommended

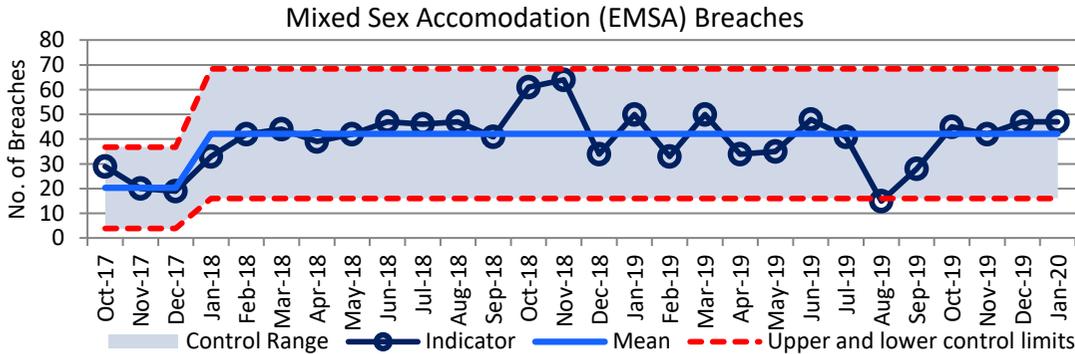
Indicator	Target	Latest data	Executive lead	Report author(s)
Patient Transport - % patients likely to recommend	90% or more	68% January 2020	Janice Sigsworth (Director of Nursing)	Guy Young (Head of Patient Experience)



Issues and root cause	The patient transport FFT response rate remains low but latest data for February 2020 shows that this doubled on the previous month and the % of patients who would recommend the service increased to 76%. Significant Patient Transport contract performance issues have existed since the service transferred to Falck in June 2019, although performance has stabilised since the beginning of January 2020.
Key updates	<ul style="list-style-type: none"> ➤ Improvements in delivery and collection times, and a reduction in incidents and complaints have been the primary focus of the management team during this period. ➤ Improvement plans for the last quarter of the 2019/20 financial year include increasing the response rate for FFT surveys to enable greater insight and continuous improvements plans to be developed jointly with the contractor. The few surveys that are being completed are currently mainly paper based.

Caring – Mixed Sex Accommodation (MSA)

Indicator	Target	Latest data	Executive lead	Report author(s)
Zero mixed-sex accommodation breaches	0	47 Jan-20	Janice Sigsworth	Felicity Bevan



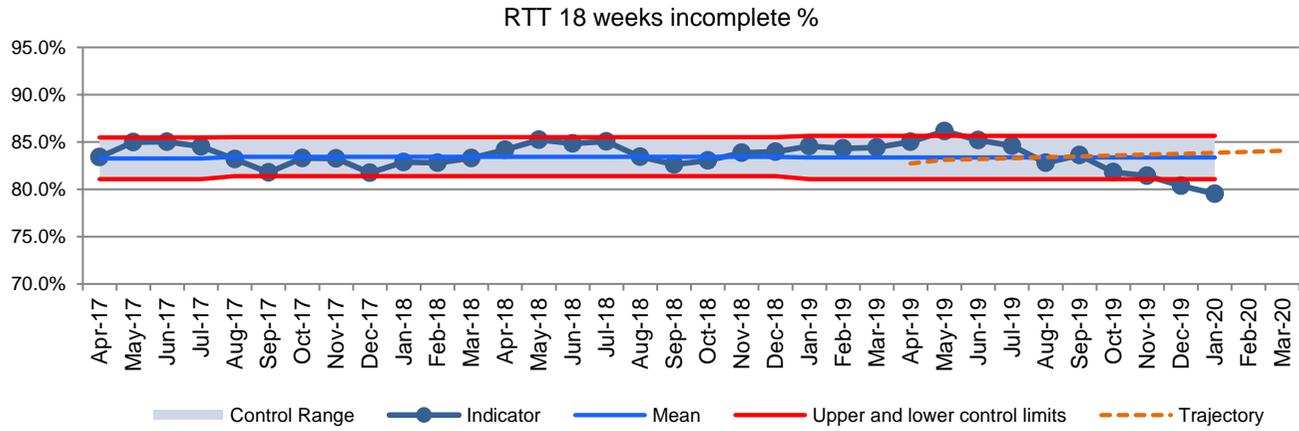
Latest performance

The Trust reported 47 mixed-sex accommodation (MSA) breaches in January 2020, which arose exclusively in the ICU's (Intensive Care Units), with patients awaiting discharge to a ward area. The breaches occur once patients are declared ready for step down to ward areas and they are waiting for a suitable bed in the most appropriate area. Increase in breaches often occur inline with increase occupancy through out the Trust which may impact on flow.

Issues and root causes	Breaches at Imperial are currently being incurred by patients awaiting discharge from the ICUs to ward areas. The root cause of MSA breaches in ICU is delayed discharge of patients within the national 4 hour target once they have been identified as fit for discharge. Downstream flow is the main obstacle. There are clinical risks associated with moving ICU patients to create single sex bays or to vacate side rooms (whereby they would not be reported as a breach). Bed moves increase the risk of cross contamination of infection and pose risk to unwell patients. There is no evidence locally (from patient feedback) that being in MSA after being declared fit for discharge has an adverse effect on patient experience.
Key updates	<ul style="list-style-type: none"> Data analysis of delayed discharges from Critical Care. [Due end February 2020 – complete] In conjunction with the Hospital Directors, discussions to be held to review the prioritisation of discharges from ICU. [In place, work ongoing to maintain focus] Provide information to patients on mixed sex accommodation within ICU, and assess impact on patients through feedback. [In place, work ongoing to maintain focus] Review amendment to national guidance. [Completed January 2020] <p><i>An amendment to national guidance on mixed sex patients has been published for critical care. Assurance work completed by the service confirms that the Trust reporting is accurate and in line with national guidance. A review by NW London commissioners of other Trusts reporting methodologies, to ensure these are in line with national guidance, is still awaited. Imperial appears an outlier for reported MSA breaches in London. However, most other London hospitals report discharge delays from ICU but report fewer or no MSA breaches. The reason for this is unclear, as the two indicators are seemingly contradictory.</i></p>

Responsive – Referral to Treatment 18 weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT patients waiting less than 18 weeks	83.9% in January 2020	79.51% in January 2020	Prof Catherine (Katie) Urch	Toyin Lawoyin, Performance Support Business Partner



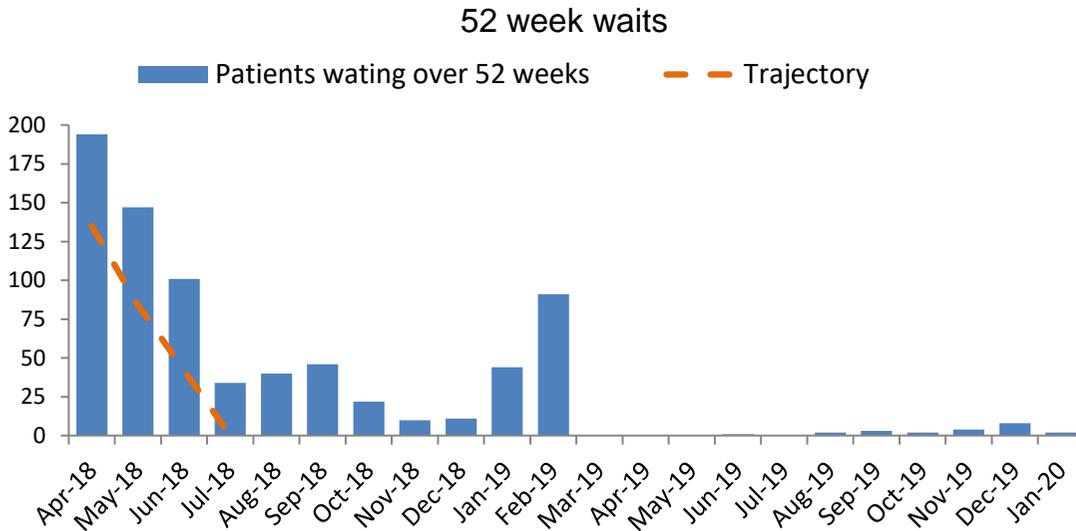
Latest performance

- The RTT waiting list size was maintained and met the trajectory.
- The performance of the standard to treat patients within 18 weeks of their referral was 79.5%, below the trajectory of 83.9%.

Issues and root causes	<ol style="list-style-type: none"> A significant percentage of the backlog is awaiting booked activity and operational actions, i.e. clinical review to determine next steps or capacity required, validation alone cannot mitigate these cohorts. Therefore validation resource has been targeted at patients with lower weeks waited to maintain waiting list size. The impact of these two scenarios has seen a continued increase in the backlog (over 18s) and a reduction in the denominator (under 18s) which negatively affects the Trusts overall performance percentage. Increasing backlog of long waiters.
Key updates	<ul style="list-style-type: none"> A review into validation processes following implementation of the Trust’s RTT validation tool (Qubit) and a central staffing model for validators commenced September 2019. The review entails a tailored approach as follows: <ul style="list-style-type: none"> Phase 1: Validation priority cohorts. These were agreed in January 2020. Testing has been completed and an evaluation is being worked through prior to full implementation. [Due end February 2020 - completed] Phase 2: Operational priorities and tolerances. This is underway which will be designed to focus operational teams resources and drive improvements in the backlog. [Due end April 2020 – on track] Phase 3: Launch of Trust wide validation framework. [Proposed June 2020]. It is recognised that some areas need reduced waits to first outpatient appointment and reduced polling ranges via the NHS e-Referral Service. These metrics are reviewed at speciality level through the performance framework meetings Ongoing review of the management of patients waiting over 40 weeks to inform a trajectory for reduction. [TBC]

Responsive – Referral to Treatment 52 week waits

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT patients waiting > 52 weeks	0	2 (January 2020)	Prof Catherine (Katie) Urch	Jan Palmer



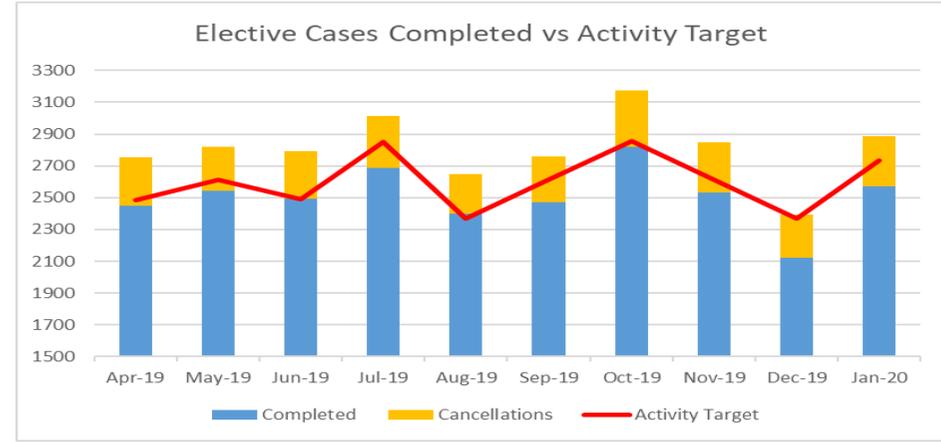
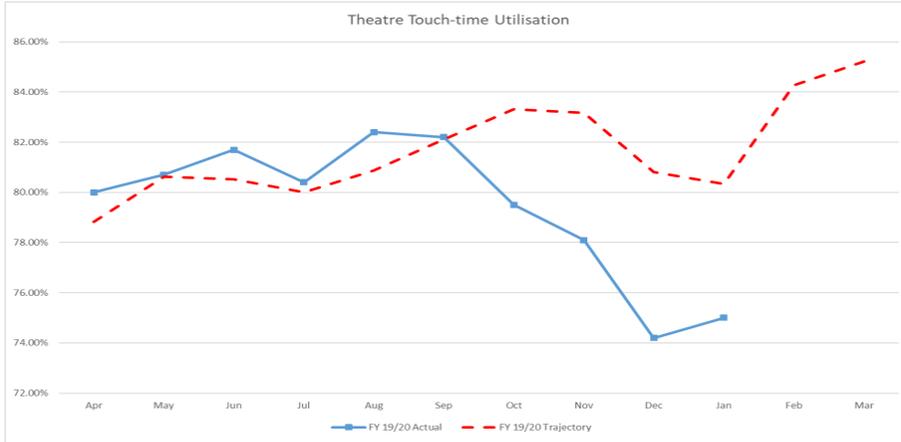
Latest performance

- At end January 2020 two patients were reported as waiting more than 52 weeks for treatment.
- The Specialties were Colorectal Surgery (1), Dermatology (1).

Issues and root causes	<p>The reported colorectal 52 week breach was also reported in December 2019. The breach reason was multifactorial and this is a clinically complex pathway and treatment is yet to be agreed.</p> <p>The dermatology pathway was an incorrect clock stop identified from November RTT Clock Stop Audit. Patient was seen on 04/02/2020 and the patient received treatment.</p>
Key updates	<p>Mitigations for tip-overs of long waiters over 40 weeks wait have been implemented as follows:</p> <ul style="list-style-type: none"> • All pathways over 40 weeks to have treatment plans in place to an end date and not just the next step in the pathway. [In place by end January 2020] [Action completed and ongoing through weekly reviews] • Local service patient tracking list meetings to align with central validation priorities to provide targeted reviews on high risk pathways. [Due end March 2020] • RTT Clock Stop Audit findings shared with the RTT Training team and stakeholders at the Elective Care Delivery Group meeting to improve and mitigate against preventable errors. [Ongoing]

Responsive – Theatre touchtime utilisation

Indicator	Target	Latest data	Executive lead	Report author(s)
Theatre touchtime utilisation	80.3% at January 2020	75.0% (corrected) at January 2020	Prof Catherine (Katie) Urch	David Woollcombe-Gosson (Programme manager)

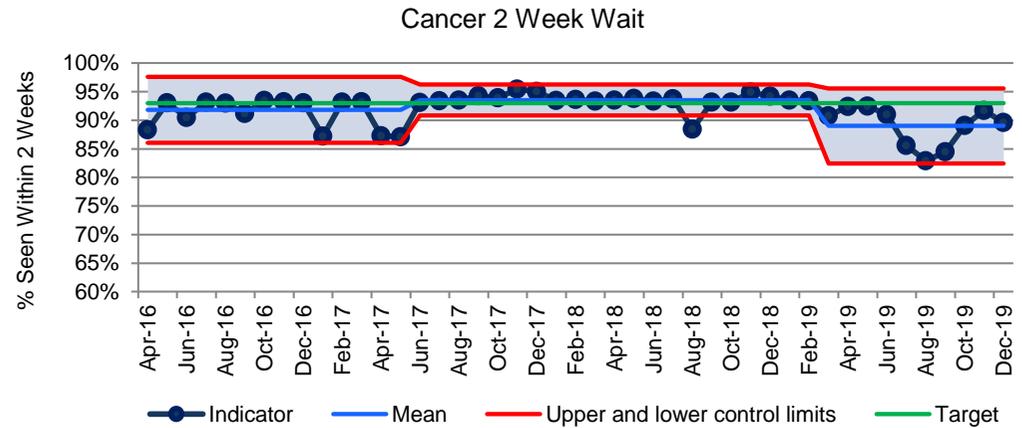


<p>Issues and root causes</p>	<ul style="list-style-type: none"> • Touchtime utilisation in January was below trajectory but +0.8% on December, counter to an anticipated further reduction. • Backfilling late notice cancellations (which remained relatively high) has been a challenge due patient choice and access to pre-operative assessment (POA), imaging and critical care beds. • Adjusted theatre schedule for New Year period to allow for bank holidays, annual leave, patient choice and bed constraints. • Continued focus on prioritising access for non-elective and urgent/2WW patients.
<p>Key updates</p>	<p>Immediate actions taken and completed:</p> <ul style="list-style-type: none"> • Initiated short-term increase in POA capacity through use of bank/agency staff. • Weekly performance summary & forecast to the Divisional Directors of Operations and General Managers to highlight any emerging issues. • Weekly supplementary list of theatre sessions at risk of <50% utilisation escalated to General Managers. • Senior management attendance at Theatre Planning Meeting to assure recovery. <p>Longer-term improvement projects:</p> <ul style="list-style-type: none"> • Senior Responsible Officer review of POA restructuring and expansion. Project review refocussed on stabilising service delivery and establishing HPB service. • Update Cerner procedure catalogue and scheduling times. [Implementation milestone April 2020] • Redesign of Cerner surgical Order Entry Forms (OEF). Emergency OEF build on track for completion in February and implementation with clinicians and theatre staff in March 2020. Build and test of elective OEFs in parallel. [On track] • Theatre schedule deep dive at site and specialty level to rebalance capacity to demand and realistic productivity. Methodology, planning assumptions and initial data analysis complete. Milestone for agreed template June 2020. [On track]

Responsive – Cancer standards (1 of 2)

Indicator	Latest data	Executive lead	Report author(s)
In December 2019 the Trust delivered six of the eight national cancer standards.	See below	Prof Catherine (Katie) Urch	Gareth Gwynn (Head of Cancer Performance)

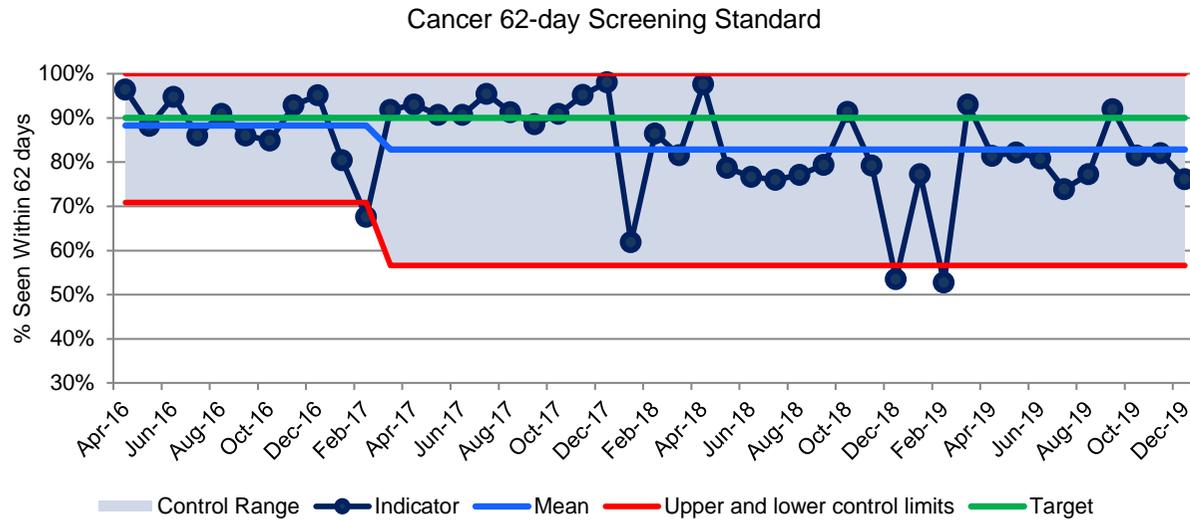
Standard	Target	Oct-19	Nov-19	Dec-19
Cancer Two Week Wait	93%	89.1%	91.7%	89.6%
Breast Symptom Two Week Wait	93%	95.0%	94.7%	93.4%
31 Day First Treatment (Tumour)	96%	96.5%	96.4%	98.0%
31 Day Subsequent Treatment - Drug Treatments	98%	100.0%	100.0%	100.0%
31 Day Subsequent Treatment - Radiotherapy	94%	95.7%	97.5%	97.1%
31 Day Subsequent Treatment - Surgery	94%	96.7%	94.5%	95.9%
Cancer Plan 62 Day Standard (Tumour) with reallocation	85%	83.7%	87.4%	89.1%
CRS 62 Day SCREENING with reallocation	90%	81.5%	82.0%	76.1%



2WW

Issues and root cause	<ul style="list-style-type: none"> Colorectal 2WW capacity impacted by significant increases in demand (35% since 17/18) and delays in delivering the straight to test model to move patients into endoscopy or CT Colonography (CTC) rather than outpatient appointments following nurse-led triage. Skin 2WW capacity has also been impacted by significant increases in demand (25% since 17/18) and challenges in securing non-locum supported first appointment clinics.
Key updates	<ul style="list-style-type: none"> Colorectal service - All patients will be managed through the Straight to test pathway. [Action completed - STT pathway live from 24/02] Colorectal service - The endoscopy service has undertaken a demand and capacity exercise and has created protected lists for cancer referrals. [Planned to commence January 2020 but delayed to March 2020] Skin service - Dermatoscopy assessment for 2WW referrals patients - capacity for this will increase from 135 patients per month in December 2019 to 269 per month in March 2020. [by March 2020] Skin service - Following successful consultant appointment, face to face capacity will increase from 208 patients per month in December 2019 to 370 in March 2020. [by March 2020] Aggregate Trust 2WW performance is expected to be compliant with the 2WW standard from February 2020

Responsive – Cancer standards (2 of 2)

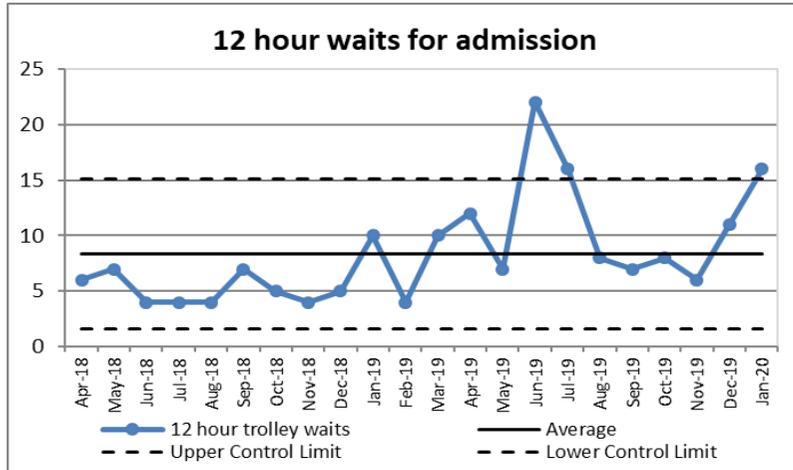


62-Day Screening

Issues and root cause	<ul style="list-style-type: none"> National breast screening service guidelines do not align with the national Cancer Waiting Times guidelines. Breast screening pathways and processes have not, therefore, been designed to meet cancer waiting times. More breast cancers are now diagnosed through screening referral than through symptomatic referral.
Key updates	<ul style="list-style-type: none"> An RM Partners working group has been established to review the delivery of the breast screening pathway A pathway mapping session with the breast screening service has identified a number of waiting times improvement opportunities through alignment of <i>diagnostic requesting processes with Cerner</i>, increasing patient communication to address non-attendance, reducing the number of multi disciplinary team (MDT) discussions before treatment and moving patients into the breast cancer MDT earlier in the pathway. Delivery dates are being agreed with the service to be completed Q4 in preparation for the changes to the cancer waiting times standards expected in Q1 2020/21. It is anticipated that the screening standard will be merged with the 62-day and consultant upgrade standards. [by end March 2020]

Responsive – A&E patients waiting more than 12 hours from decision to admit

Indicator	Target	Latest data	Executive lead	Report author(s)
No. of waits for admission over 12 hours from decision to admit (DTA)	0 breaches	16 breaches – Jan 2020	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



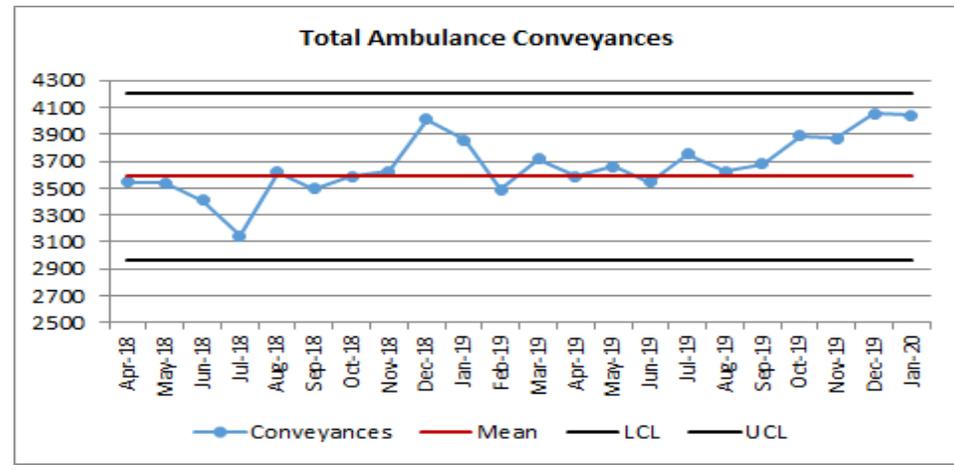
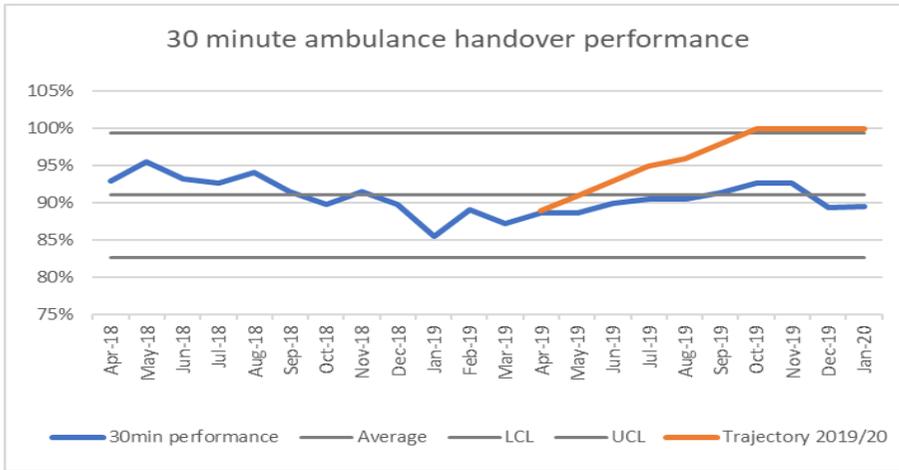
Latest performance

- 16 confirmed twelve hour breaches of wait from decision to admit (DTA) to admission in January 2020 compared with 11 in December 2019.
- All 16 breaches were Mental Health (14 at SMH and 2 at CXH).
- These patients spent an average of 30 hours in the department and 23 hours from DTA to admission both figures increasing marginally from December 2019.
- Mental health referrals remained stable at CXH (avg.5/day) and increased at SMH (from avg. 6.2/day Dec 19 to avg.7.6/day Jan 20).
- The number of patients on mental health pathways spending a total of 12 hours in the Emergency Department (ED) (new UEC standard) was 58 in January 2020 a decrease from 70 in December 2019, and similar to the number for November 2019 (54).

Issues and root causes	<p>Mental Health issues:</p> <ul style="list-style-type: none"> • Lack of mental health beds. • Higher than average proportion of out of area patients requiring repatriation to their local hospital. • Delays with out of hours Home Treatment Team and Approved Mental Health Professional at SMH.
Key Improvement Actions	<p>Mental Health actions:</p> <ul style="list-style-type: none"> • The first cross site Big Room on mental health in ED took place on 4 Feb. Joint priorities for improving safety and experience for staff and patients agreed. These priorities mainly focus on communication and patient experience. • Crowd or charitable funding for development of mental health therapeutic courtyard in ED at CXH launch 27 January – delivery expected June 20, on track. • Close collaboration between ICHT and MH providers at executive level – ongoing. • Refresh of compact escalation protocols to ensure earliest and most senior escalation. [Meeting held 5 March]. • Collaboration between MH providers locally to ensure MH compact principles are followed continues. • Following Health Education England (HEE) grant received, a training package is being designed for general nurses in mental health. • In process of agreeing with commissioners potential reallocation of MH winter pressures funding to ED, to mitigate increased MH spend during winter.

Responsive – Ambulance Handovers

Indicator	Target	Latest data	Executive lead	Report author(s)
No ambulance handover delays >30 minutes	100% <30 minutes	Jan 2020 89.5% < 30 minutes	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



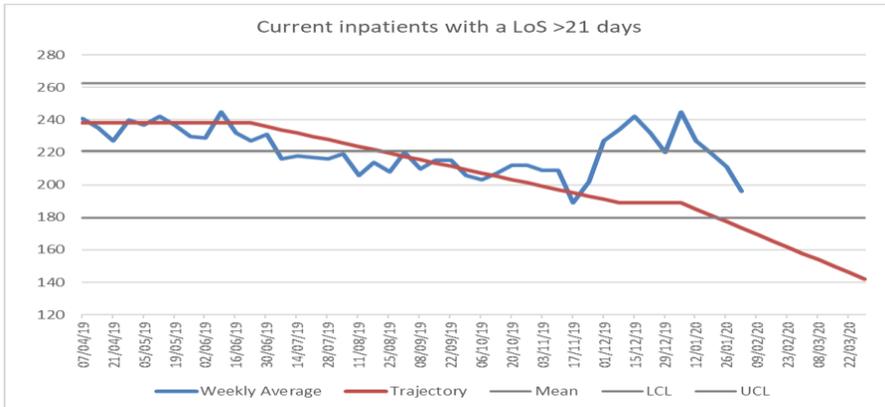
Latest performance

- Performance against the 30 minute handover standard overall for the Trust increased to 89.5% in January 2020. This is 10.5% below trajectory.
- Performance at CXH improved compared to previous month at 98% in January 2020 and was the second highest performing hospital against this metric in NWL sector for the month. CXH continues to push and aim for 100%.
- SMH 30 minute handover performance decreased by 0.2% from 83.8% to 83.6% in January 2020. Within NWL sector SMH ranked sixth out of seven.
- Conveyances were at a similar level between December 2019 and January 2020, however they were 5% higher than January 2019.

Issues and root causes	<ul style="list-style-type: none"> • Capacity in the system including availability of cubicles in ED at SMH • Influx of arrivals in a short period of time. • Conveyances up by 10% at CXH and 2% at SMH comparative to same period 2019. • Acuity/complexity of arrivals, and linked with this at SMH number of Rapid Nurse Assessment spaces (2 trolleys and seats) • Ensuring consistent availability of nursing staff to facilitate handover while managing other demands in the department.
Key Improvement Actions	<ul style="list-style-type: none"> • Improvement plan for SMH will be shaped by a stakeholder event as part of the joint working with LAS operational leads. Ongoing timescales • The override work in the LAS software to record ambulance arrivals completed, plan to review again in April 2020. • Audit of 30 minute breaches has been completed and results are currently being reviewed, the data suggests that changes in practice could improve performance. The general manager to take forward with London Ambulance Service and NWL performance team. – Feb/Mar 20 • CXH aiming to achieve 100% by March 2020, and SMH aiming to recover to 90% by March 2020.

Responsive – Long Length of Stay

Indicator	Ambition	Latest data	Executive lead	Report author(s)
Reducing long length of stays (LLOs) for inpatients	<=142 occupied beds by March 2020, January trajectory <=181	Avg. occupied beds 224 – January 2020	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



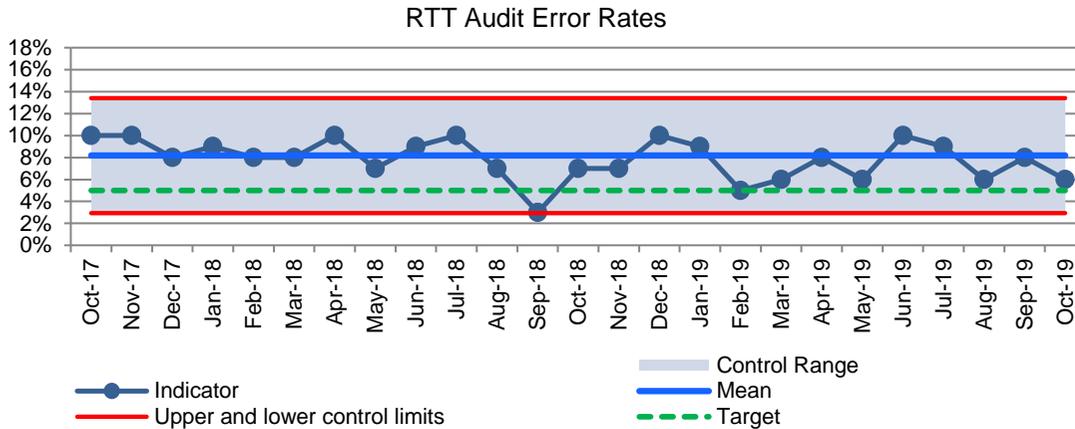
Latest performance

- In January 2020 there was an average of 224 occupied beds with patients with a length of stay greater than 21 days.
- This is 43 higher than the expected trajectory average for the month and presents a significant challenge to the achievement of the required 40% reduction by March
- The figures equates to 23% of occupied beds (excl. paediatrics / maternity) and represents an 5.9% reduction on baseline.
- The graph shows progression against the weekly trajectory. Whilst improvements during January have been made it is unlikely the Trust can reduce to the trajectory of 142 occupied beds by March 2020.

Issues and root causes	<ul style="list-style-type: none"> • Seasonal increase in patient volumes and complexity of case-mix across all sites and specialties, along with an increase in the number of patients coded as fit but not moving in a timely way • Variations in use of Red 2 Green/board rounds and varying effectiveness of LLOS review meetings • Variations in understanding and application of patient choice policy • Lack of leverage with care home providers using “challenging behaviour” as reason to reject referrals • Reduced capacity in community bedded facilities (especially for patients with perceived of real challenging behaviours) creating discharge blockages including closure of eight beds at Garside. • Re-organisation of NWL Continuing Healthcare teams causing delays to fast track nursing home placements
Key Improvement Actions	<ul style="list-style-type: none"> • Board round audit to baseline effective use of board rounds and Red 2 Green methodology including; a) guideline, b) escalation process, c) embedding into the ward culture, and d) developing the Associate Medical Director role at site level – by 31 March • Full implementation of the choice policy including; a) continuing rollout of training, and b) confidence/usage of policy – by 28 Feb [extended to 31 March to account for no. of staff to be trained] • Engagement with bi-borough care home operators via Local Authority contract meetings to influence capacity to support patients with real or perceived behavioural challenges – by 28 Feb [extended to 31 March to gather patient stories] • Monitoring implementation of nursing home assessment protocol – ongoing • Iteration towards consistent LLOS review meetings including; a) clinical leadership and challenge, b) a home first attitude and c) closing the loop on actions – ongoing with the emergency care intensive support team (ECIST) focusing on HH site, started engagement with surgical wards w/c 3 Feb • Relational engagement with non-NWL CCGs – On track for 15 March • Reinvigoration of medium term plans with ongoing support from ECIST. [Attendance at 2 day workshop attended in February to be reflected in next update]

Responsive – RTT Audit Error Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT Audit Error Rate	5%	6% (Oct 2019)	Prof Catherine (Katie) Urch; Claire Hook.	Caroline O’Dea (Business Partner, Performance Support Team)



Latest performance

- The Trust latest RTT Audit error rate reported for October 2019 was 6%. This equates to a total of 62 incorrect clock stops found through audit for the submission month of October 2019.

Issues and root cause	<ul style="list-style-type: none"> Root cause analysis has shown themes consistent with those reported over the last year, the key action associated with incorrect clock stops continues to be check out from outpatient clinics and the most frequently used RTT codes when applying incorrect clock stops are code 34 – no treatment patient discharged. The number of incorrect clock stops using code 32 – clinician/hospital initiated active monitoring has reduced slightly in October audit but still appears in the top 3 incorrectly applied codes.
Key updates and improvement actions	<ul style="list-style-type: none"> The Trust error rate has reduced by 2% when compared to the previous month and all three divisions have reported a decrease in error rates. The error rate for long waiting patients (at 38 weeks and above) has also decreased when compared to last month, by 2% and is now reported within the 5% target threshold at 4%. The Elective Care Training Team continues to provide both speciality-specific and rapid response training aligned to the results of the RTT audit and monthly data quality performance. An annual review is currently taking place which will summarise the last 12 months output and impact alongside making recommendations for objective and priorities in 20/21. The RTT audit error rate is still expected to return to best practice 5% error rate in November 2019, with a dependence on multiple transitional work streams in the Surgery division including (i) replacing agency validation teams with substantive pathway co-ordination teams; (ii) Qubit Phase 3 roll-out including management reporting tools which will facilitate smart validation to maximise benefits; and (iii) roll-out of the elective care training rapid response and learning cycle.

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Finance Report for February 2020	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input checked="" type="checkbox"/> Discussion <input type="checkbox"/> Information
Date of Meeting: 25 th March 2020	Item 11, report no. 08
Responsible Executive Director: Jazz Thind, Chief Financial Officer	Author: Des Irving-Brown, Deputy Chief Finance Officer Michelle Openibo, Associate Director: Business Partnering
<p>Summary:</p> <p>This paper provides the Board with an update on the financial position for the Trust for the eleven months to the 29th February 2020.</p> <p><u>Key highlights:</u></p> <ul style="list-style-type: none"> • actual year to date deficit of £8.8m (on plan) before Provider Sustainability Funding (PSF) • additional income associated with over performance in activity, mainly in relation to emergency work, is offset by the additional costs of delivery • income payable by NWL CCGs and NHSE in relation to 19/20 agreed • remain on track to meet control total through further non-recurrent actions/mitigations (one-offs) which result in a significant pressure being carried forward into 20/21 • all divisions to achieve their current forecast outturn position • continued concerted effort to reduce pay exit run rate to support delivery of outturn and 20/21 financial plan • additional costs associated with COVID-19 are funded centrally (c£0.6m of revenue costs to 31st March 2020) • unless operational teams are able to close the £4.4 gap to the control total the total amount of non-recurrent support required will equate to £24m <p><u>Key Risks or areas of concern impacting delivery of control total:</u></p> <ul style="list-style-type: none"> • As NHS clinical income for the year is now fixed any increase in the cost forecast over the current position is a risk to the trust • The additional costs associated with the in-housing of hotel services (capital and revenue) continue to be updated and quantified <p><u>Capital resource limit:</u></p> <p>Capital expenditure is £2.4m behind plan but forecast to catch up in order that the Trust meets its capital resource limit of £51.9m.</p>	
Recommendations: The Committee is asked to note this paper	
This report has been discussed at: N/A	

<p>Quality impact: This paper relates the CQC domain well-led.</p>
<p>Financial impact: The financial impact of this proposal as presented in the paper enclosed: 1) Has no financial impact</p>
<p>Risk impact and Board Assurance Framework (BAF) reference: This report relates to risk ID:2473 on the trust risk register - Failure to maintain financial sustainability</p>
<p>Workforce impact (including training and education implications): N/A</p>
<p>Has an Equality Impact Assessment been carried out or have protected groups been considered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable If yes, are further actions required? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>What impact will this have on the wider health economy, patients and the public? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable</p>
<p>The report content respects the rights, values and commitments within the NHS Constitution <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Trust strategic goals supported by this paper:</p> <ul style="list-style-type: none"> ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
<p>Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <ul style="list-style-type: none"> ▪ Should senior managers share this information with their own teams? Yes

FINANCE REPORT – 11 MONTHS ENDED 29th February 2020**1. Introduction**

This report provides a brief summary of the Trust's financial results for the 11 months ended 29th February 2020

2. Financial Performance

The Trust has set a plan to meet the control total of £16.0m deficit before Provider Sustainability Funding (PSF) and Marginal Rate Emergency Threshold Funding (MRET). After this funding the Trust is planning to deliver a £11.1m surplus. The Trust expects to meet the control total for the year.

Key highlights:

- actual year to date deficit of £8.8m (on plan) before Provider Sustainability Funding (PSF)
- additional income associated with over performance in activity, mainly in relation to emergency work, is offset by the additional costs of delivery
- income payable by NWL CCGs and NHSE in relation to 19/20 agreed
- remain on track to meet control total through further non-recurrent actions/mitigations (one-offs) which result in a significant pressure being carried forward into 20/21
- all divisions to achieve their current forecast outturn position
- continued concerted effort to reduce pay exit run rate to support delivery of outturn and 20/21 financial plan
- the Trust has been advised to assume that any reasonable additional costs incurred for Covid-19 will be reimbursed and this is assumed within the forecast position. The Trust currently has c £0.3m of costs in the year to date position which mainly sit within Medicine and Integrated Care Division.
- unless operational teams are able to close the £4.4 gap to the control total the total amount of non-recurrent support required will equate to £24m

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	93.85	100.41	6.56	1,059.36	1,088.86	29.50
Pay	(54.61)	(56.34)	(1.73)	(595.08)	(610.47)	(15.39)
Non Pay	(39.50)	(44.39)	(4.89)	(441.84)	(454.34)	(12.50)
Internal Recharges	0.00	(0.00)	(0.00)	0.00	0.00	(0.00)
Reserves	(1.44)	(1.05)	0.39	2.11	1.19	(0.93)
MRET Income	0.85	0.85	-	9.38	9.38	-
EBITDA	(0.85)	(0.53)	0.33	33.93	34.62	0.69
Financing Costs	(3.41)	(4.26)	(0.85)	(39.64)	(42.50)	(2.87)
SURPLUS / (DEFICIT) inc. donated asset treatment	(4.26)	(4.79)	(0.52)	(5.71)	(7.88)	(2.17)
Donated Asset Treatment	(0.47)	0.02	0.49	(3.10)	(0.91)	2.18
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT) before PSF	(4.74)	(4.77)	(0.03)	(8.80)	(8.80)	0.01
PSF Income	1.97	1.97	(0.00)	14.88	15.84	0.96
SURPLUS / (DEFICIT) after PSF	(2.77)	(2.80)	(0.03)	6.07	7.05	0.97

2.1 Provider Sustainability Funding

PSF is assessed on a quarterly basis on achievement of the control total. Based on the current position the Trust is assuming 100% achievement of 2019/20 PSF. The Trust has received an additional £0.97m of PSF relating to 2018/19. This funding cannot be used to help meet the control total.

2.2 NHS Activity and Income

The summary table shows the position by division. The Trust is over plan on income year to date for both local and specialist commissioners. In this year's contract with NWL commissioners, the Trust has a cap of 1% before over performance is paid after which we are paid marginal rate of 70%. Based on current activity the marginal rate for the trust is c55% of income. The Trust has agreed payment of income over performance with both local and specialist commissioners.

Divisions	Year to Date Activity			Year to Date Income (£M)		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	895,902	814,169	(81,733)	264.87	276.41	11.54
Division of Surgery, Cancer & Cardio.	703,840	729,790	25,950	332.46	324.49	(7.97)
Division of Women, Children & Clin. Support	394,836	413,573	18,737	144.37	145.66	1.29
Clinical income	1,994,578	1,957,533	(37,045)	741.70	746.56	4.86
Central Income	115,152	131,153	16,001	110.41	128.15	17.74
Pathology	2,033,611	2,260,042	226,432	10.45	10.84	0.39
Clinical Commissioning Income	4,143,341	4,348,729	205,388	862.56	885.55	22.99

Medicine and Integrated Care (MIC) is over performing on emergency activity across all sites. Within Surgery, Cancer and Cardiovascular (SCC) there is underperformance on electives, within cardiac services and trauma directorate. Women, Children and Clinical Support (WCCS) is ahead of plan year to date with additional activity over plan in paediatric care, gynecology and imaging. The division is behind plan in maternity with fewer births, a trend that has been in place for a number of years.

2.3 Private Patient Income

Private income is ahead of plan year to date and in month. There has been significant growth in private income across the Trust in but this has mainly been within the first 8 months of the year. The clinical teams and Imperial Private Health team have been working to identify further growth plans for private activity in future years.

2.4 Clinical Divisions

The financial position by clinical division is set out in the table below.

		In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	24.24	26.28	2.05	280.13	292.07	11.95
	Expenditure	(18.15)	(20.60)	(2.45)	(203.85)	(220.76)	(16.91)
	Internal Recharges	(1.05)	(0.71)	0.34	(11.57)	(11.27)	0.30
	Total	5.04	4.97	(0.07)	64.70	60.05	(4.66)
Surgery, Cancer and Cardiovascular	Income	29.35	29.93	0.57	337.29	329.03	(8.26)
	Expenditure	(25.60)	(25.97)	(0.36)	(282.47)	(282.39)	0.08
	Internal Recharges	1.48	2.54	1.05	16.31	17.07	0.76
	Total	5.23	6.50	1.27	71.14	63.72	(7.42)
Women, Children & Clinical Support	Income	13.38	13.61	0.23	150.14	150.15	0.01
	Expenditure	(13.79)	(14.05)	(0.26)	(151.77)	(153.35)	(1.58)
	Internal Recharges	2.03	1.80	(0.23)	21.31	20.80	(0.51)
	Total	1.61	1.35	(0.26)	19.68	17.60	(2.08)
Imperial Private Healthcare	Income & Expenditure	2.45	2.25	(0.21)	25.48	25.59	0.10
	Internal Recharges	(2.46)	(3.62)	(1.16)	(26.06)	(26.61)	(0.56)
	Total	(0.01)	(1.37)	(1.37)	(0.57)	(1.02)	(0.45)
Total Clinical Division		11.88	11.45	(0.43)	154.95	140.34	(14.61)

MIC is £4.7m worse than plan year to date mainly due to delays in the efficiency programme. There is significant emergency income over performance within the division with additional costs to deliver the activity, especially in nursing. The division has also incurred additional costs in the year for overseas nurse recruitment.

SCC is £7.4m worse than plan year to date. The division is underperforming on income with reduced costs in clinical areas. The division is also under achieving on their efficiency programme by £1.7m year to date. In month there has been an adjustment to internal recharges for costs, this is driving a £1m benefit in SCC offset in IPH.

WCCS is £2.1m worse than plan year to date. The key driver of the position is under delivery of efficiency plans of £2.0m.

Imperial Private Health (IPH) is £0.5m adverse to plan, overall income is ahead of plan with cost increases.

3. Efficiency programme

The Trust has set a Cost Improvement Plan (CIP) of £57m to meet the deficit plan for the year. The Trust is £12.5m worse than plan year to date on where plans for CIPs have not been identified. The Project Management Office is working with operational teams to identify recurrent savings for 2020/21 to deliver next year's plan.

4. Cash

Cash balances at the end of December were £49.4m an increase of £22.7m since the start of the year, due to the receipt of PSF payments from NHSI (including payments for 2018/19). Cash has decreased by £0.8m in Month 11, driven by additional capital payments. The Trust must maintain a cash balance of £3m to meet loan conditions.

5. Capital

The Trust has spent £42.7m of capital against a plan of £45.2m, this underspend has been due to the phasing of specific projects. Where these changes in timing have resulted in projects moving into next financial year alternative schemes from the capital pipeline have been agreed to be brought forward to ensure that the Capital Resource Limit of £51.9m is met.

6. Conclusion

The Trust is on plan year to date and is expected to meet the control total. The Trust must identify and deliver recurrent efficiencies to ensure that the plan for next year is achievable.

7. Recommendation

The Trust Board is asked to note the report.

TRUST BOARD - PUBLIC REPORT SUMMARY

Title of report: National Staff Survey results 2019	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information
Date of Meeting: 25 March 2020	Item 12, report no. 09
Responsible Executive Director: Kevin Croft, Director of People and OD	Author: Sue Grange, Deputy Director of People and OD

Summary:

This paper summarises the results of the National Staff Survey which was carried out between September 2019 and December 2019. It outlines the high level Trust wide results and makes recommendations for action in both communicating the results and taking action as a result of the results.

The Trust undertook a full census survey in 2019, following several years of a 10% sample survey. A total of 52% of staff responded to the survey (5,659 out of 10,988), which is significantly higher than any other staff survey run. The overall engagement score was 7.2 out of 10, up from last year at 7.0 and above this year's average score for all acute Trusts which was also 7.0.

The survey results are split into 11 Themes, and scores across all themes improved. Results are above the national average in six out of the eleven themes; immediate managers, quality of appraisals, quality of care, safety culture, staff engagement, team working. However, scores remain below the national average for acute Trusts in 4 key areas and these are recommended as the 4 key areas of Trust priority focus :-

- equality diversity and inclusion
- health and well being
- morale
- Safe environment :bullying and harassment

The overall results would suggest that many of the work programmes initiated in 2018-9 are having an impact and potentially contributing to the improvements in survey results.

The paper also outlines the Trust Culture work programme which is the overarching programme to drive a range of projects and action in response to the survey feedback, within five key themes including:

- (i) Living our Values
- (ii) Work, workplace and well being
- (iii) Fairness, Equity and inclusion
- (iv) Identity, belonging and understanding
- (v) Leadership, learning and improvement

The paper was discussed at the Executive Committee on 10th March 2020, and it was agreed that whilst there is much to celebrate in the results, there is also a very clear recognition of the work still to do. The changes agreed as a result of the executive discussion are included:

- an increase in the focus on implementing "Just Culture" which links to the culture for staff involved in patient safety incidents

<ul style="list-style-type: none"> • a reminder to continually focus on how we translate the Trust actions we are taking into tangible changes for front line staff • a request to incorporate the Freedom to speak up guardians in all the wider actions being taken, events and communications linked to both the Values programme and the staff survey feedback
<p>Recommendations: The Board is asked to note:</p> <p>(i) The 2019 results of the NHS Staff Survey and the recommended actions</p> <p>(ii) The proposed Culture work programme to drive forward the key priorities arising out of the Staff Survey results?</p>
<p>This report has been discussed at: Executive People & OD Committee</p>
<p>Quality impact: Staff engagement has an indirect impact on the quality of patient experience</p>
<p>Financial impact: Has no financial impact : Funding has already been identified</p>
<p>Risk impact and Board Assurance Framework (BAF) reference: Incorporated in actions.</p>
<p>Workforce impact (including training and education implications): Staff Survey feedback is a critical KPI of our workforce, and links to vacancy rates, turnover, performance</p>
<p>Has an Equality Impact Assessment been carried out or have protected groups been considered? <input checked="" type="checkbox"/> Not applicable</p>
<p>What impact will this have on the wider health economy, patients and the public? NA</p>
<p>The report content respects the rights, values and commitments within the NHS Constitution <input checked="" type="checkbox"/> Yes</p>
<p>Trust strategic goals supported by this paper: Retain as appropriate:</p> <ul style="list-style-type: none"> ▪ To build learning, improvement and innovation into everything we do
<p>Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, why?.....</p> <p>If the details can be shared, please provide the following in one to two line bullet points:</p> <ul style="list-style-type: none"> • The 2019 Staff Survey results have been published and show an improved engagement score of 7.2 compared to 7.0 in 2018 and an Acute trust average of 7.0

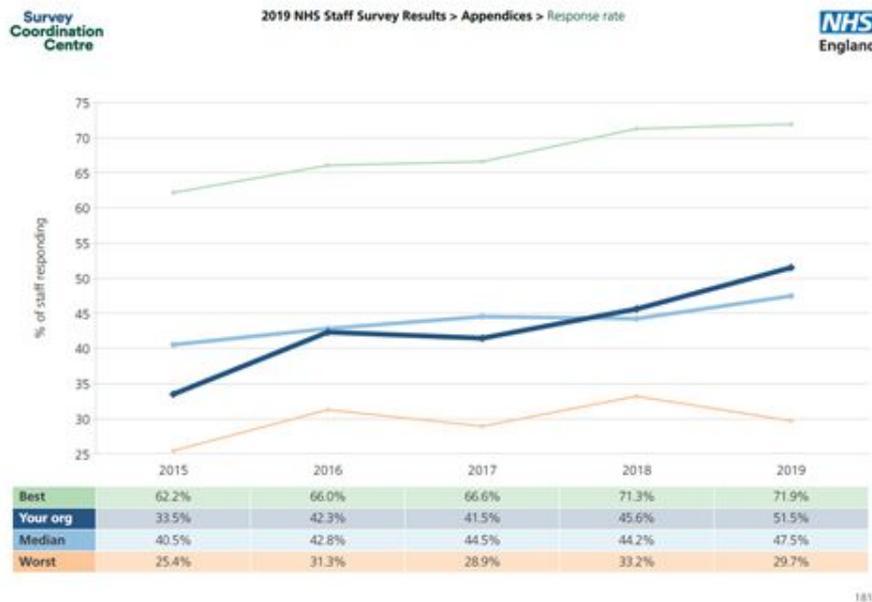
Introduction

The National staff survey was carried out in the Trust in September to December 2019. In the last 5 years the Trust has run a sample 10% survey and a local survey but in 2019 we reverted to a full national census survey of all staff.

1. Response rate

A total of 52% of staff responded to the survey (5,659 out of 10,988), which is significantly higher than any other staff survey run at the Trust. The median response rate for Acute Trusts was 47.5% and the national response rate across the whole of the NHS was 48%.

Table 1: Response rates over time



2. Overall Engagement

Our overall engagement score was **7.2 out of 10**.

This comprises questions on:

- Advocacy (Staff recommendation as a place to work or receive treatment)
- Motivation (staff motivation at work)
- Involvement (staff ability to contribute towards improvement at work)

This is an increase from 7.0 in 2018 and is above the average for Acute Trusts which was also 7.0.

3. Theme Scores

The survey results are divided into 11 themes.

3.1. Theme scores over time

Table 2 below shows our themes scores over time and Appendix 1 gives a breakdown of themes scores over 5 years. All theme scores have improved since last year, with 7 showing a significant improvement.

Table 2: Themes Scores 2018-2019

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	8.4	520	8.6	5491	↑
Health & wellbeing	5.6	534	5.7	5540	Not significant
Immediate managers	6.6	533	7.0	5585	↑
Morale	5.7	516	6.0	5485	↑
Quality of appraisals	5.8	451	5.9	4850	Not significant
Quality of care	7.7	492	7.8	5118	Not significant
Safe environment - Bullying & harassment	7.3	523	7.6	5505	↑
Safe environment - Violence	9.3	517	9.4	5525	Not significant
Safety culture	6.6	523	6.8	5523	↑
Staff engagement	7.0	545	7.2	5642	↑
Team working	6.4	539	6.7	5538	↑

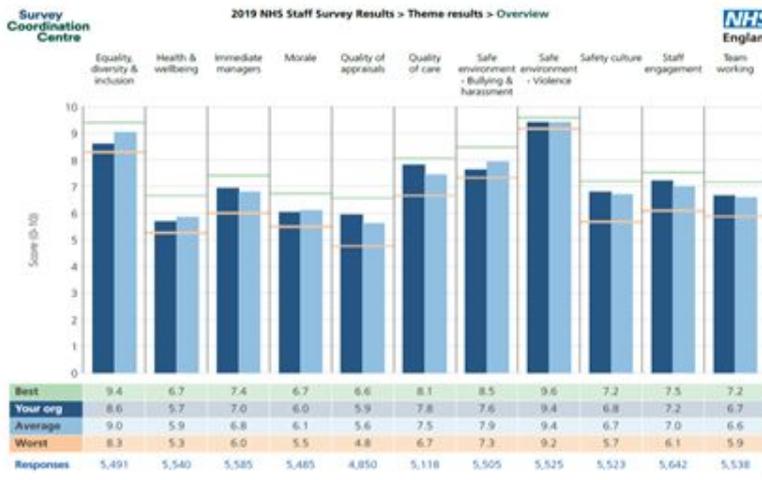
* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

3.2. Theme Results compared with the Acute Sector scores

Table 3 shows our theme results compared with the Acute Sector Trust average. This shows that despite the improvements over time, we are still below the average or Acute Trusts in

- Equality Diversity and Inclusion
- Health and well-being
- Morale
- Safe environment – Bullying and Harassment

Table 3: 2019 Staff Survey scores by theme



4. Action Planning and Next Steps

4.1. Trust wide action

The overall results would suggest that many of the Trust wide work programmes initiated in 2018-9 are having an impact and potentially contributing to the improvements in survey results. There are clearly 4 themes which remain below average and should remain a high priority

- **Equality, Diversity and Inclusion**
- **Health and Well being**
- **Morale**
- **Bullying and Harassment**

These themes will be included in the Trust “Culture Programme” outlined below.

Table 4 : Trust Culture Programme

Improving our organisational culture	Living our values	<ul style="list-style-type: none"> •Values workshops •Asking, receiving and giving feedback •Active bystander •HOTT programme •Safety workstreams
	Work, workplace and wellbeing	<ul style="list-style-type: none"> •Digital collaborative working - O365 and integrating systems •Agile and mobile working approach •Investing in work environment and facilities •Health and wellbeing strategy
	Fairness, equity and inclusion	<ul style="list-style-type: none"> •Equality, diversity and inclusion plan •Freedom to speak up focus •Unconscious bias •Just culture
	Identity, belonging and understanding	<ul style="list-style-type: none"> •Brand, brand hierarchy and naming •Redevelopment of digital platforms to reflect user –focus •‘Front-of-house’ and user-focused approach to public areas • Effective team working • Imperial management system – improvement, involvement
	Leadership, learning and improvement	<ul style="list-style-type: none"> •Objective setting, appraisal and performance management •Leadership programme development and strategy •Career management frameworks and support •Improvement capabilities and innovation mindset •ACE programme for admin and clerical workforce

This programme will be led through a Culture Steering Group, chaired by Kevin Croft. Some projects have their own governance arrangements already, which are currently being mapped and will continue (see Appendix 1).

4.2. Local Action

Divisions and Directorates have more detailed results to support local action planning. Divisions are encouraged to now analyse and use results at Divisional, Directorate and Ward/department level (where possible) to target interventions locally where required.

- What are the issues in each Directorate/department?
- How does this compare with other sources of data? Turnover? Sickness? WAP results
- What are your key local actions?
- Which are the 4-5 departments that require focused action?
- which actions do we want to STOP/START /CONTINUE based on the 2019 results

4.3. Communication of results

All Divisions are asked to communicate the results back to staff and to consider how to celebrate and recognise the managers and teams who have contributed to the improved results in the themes of:-

- Immediate managers

- Safety Culture
- Quality of appraisals
- Job Satisfaction
- Senior Mangers
- Quality of Care
- Team working

5. Recommendations

The Board is asked to note the following action:

- (iii) The 2019 results of the NHS Staff Survey and the recommended actions
- (iv) The proposed Culture work programme to drive forward the key priorities arising out of the Staff Survey results

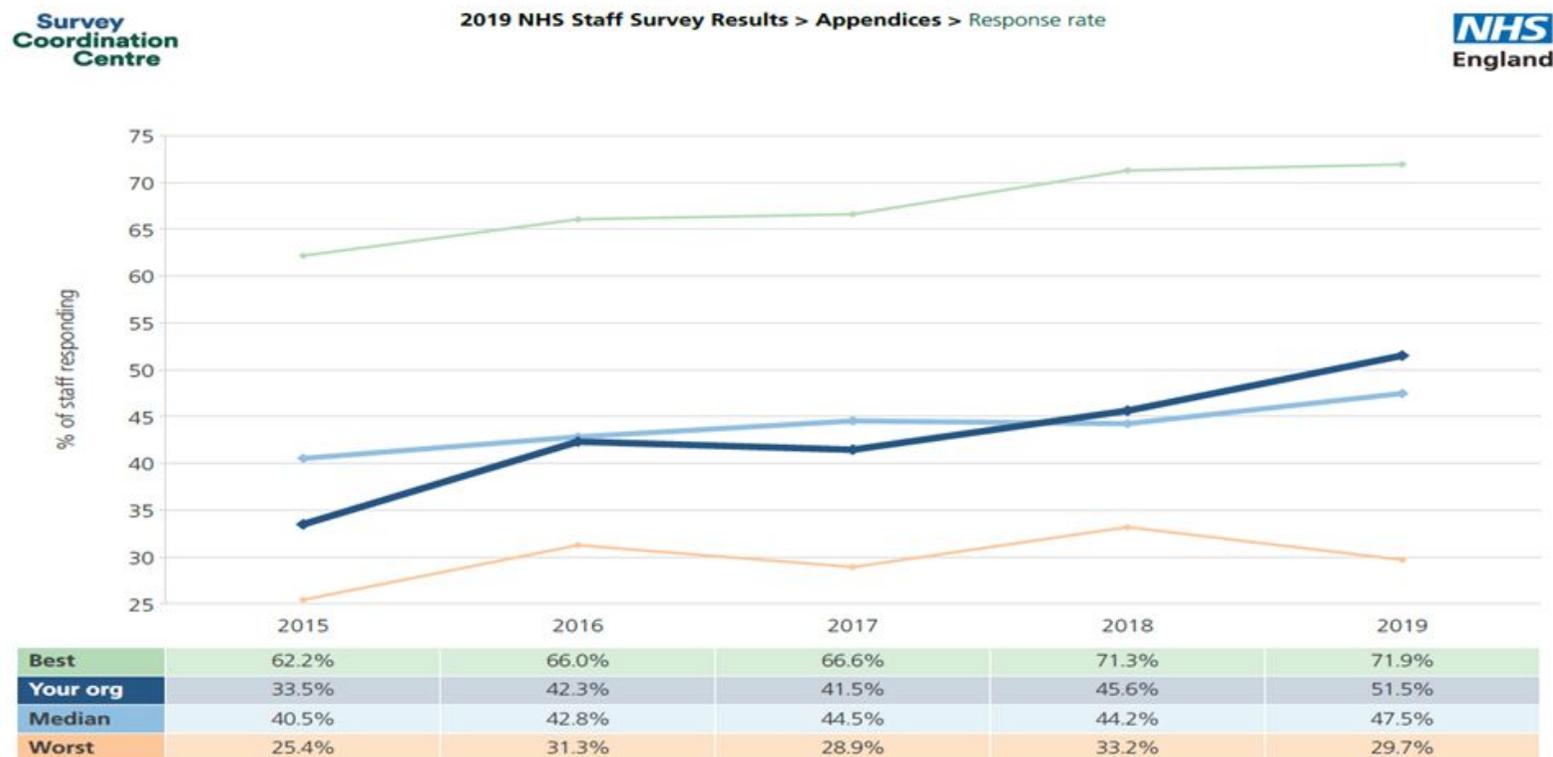
National Staff Survey Results 2019

Kevin Croft



Response Rates

Response rate increased to 52% of a full census, which is 5659 total responses; our highest response rate to date



Overall Staff Engagement Score

Overall Staff Engagement is measured as an average across these three themes. Staff Engagement scores fall between 0 and 10, where the higher the score, the more engaged the staff.

In the National Staff Survey, Staff Engagement is measured across three sub-sections of Theme 10:

- **Advocacy**, measured by Q21a, Q2c and Q21d (Staff recommendation of the trust as a place to work or receive treatment).
- **Motivation**, measured by Q2a, Q2b and Q2c (Staff motivation at work).
- **Involvement**, measured by Q4a, Q4b and Q4d (Staff ability to contribute towards improvement at work).

Overall Trust Staff Engagement Score 2019: 7.20

- This is an improved position compared to 2018, when it was 7.0
- Acute Sector average 2019 was 7.0

Engagement Score 2018-2019

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: **↑** indicates that the 2019 score is significantly higher than last year's, whereas **↓** indicates that the 2019 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	8.4	520	8.6	5491	↑
Health & wellbeing	5.6	534	5.7	5540	Not significant
Immediate managers	6.6	533	7.0	5585	↑
Morale	5.7	516	6.0	5485	↑
Quality of appraisals	5.8	451	5.9	4850	Not significant
Quality of care	7.7	492	7.8	5118	Not significant
Safe environment - Bullying & harassment	7.3	523	7.6	5505	↑
Safe environment - Violence	9.3	517	9.4	5525	Not significant
Safety culture	6.6	523	6.8	5523	↑
Staff engagement	7.0	545	7.2	5642	↑
Team working	6.4	539	6.7	5538	↑

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

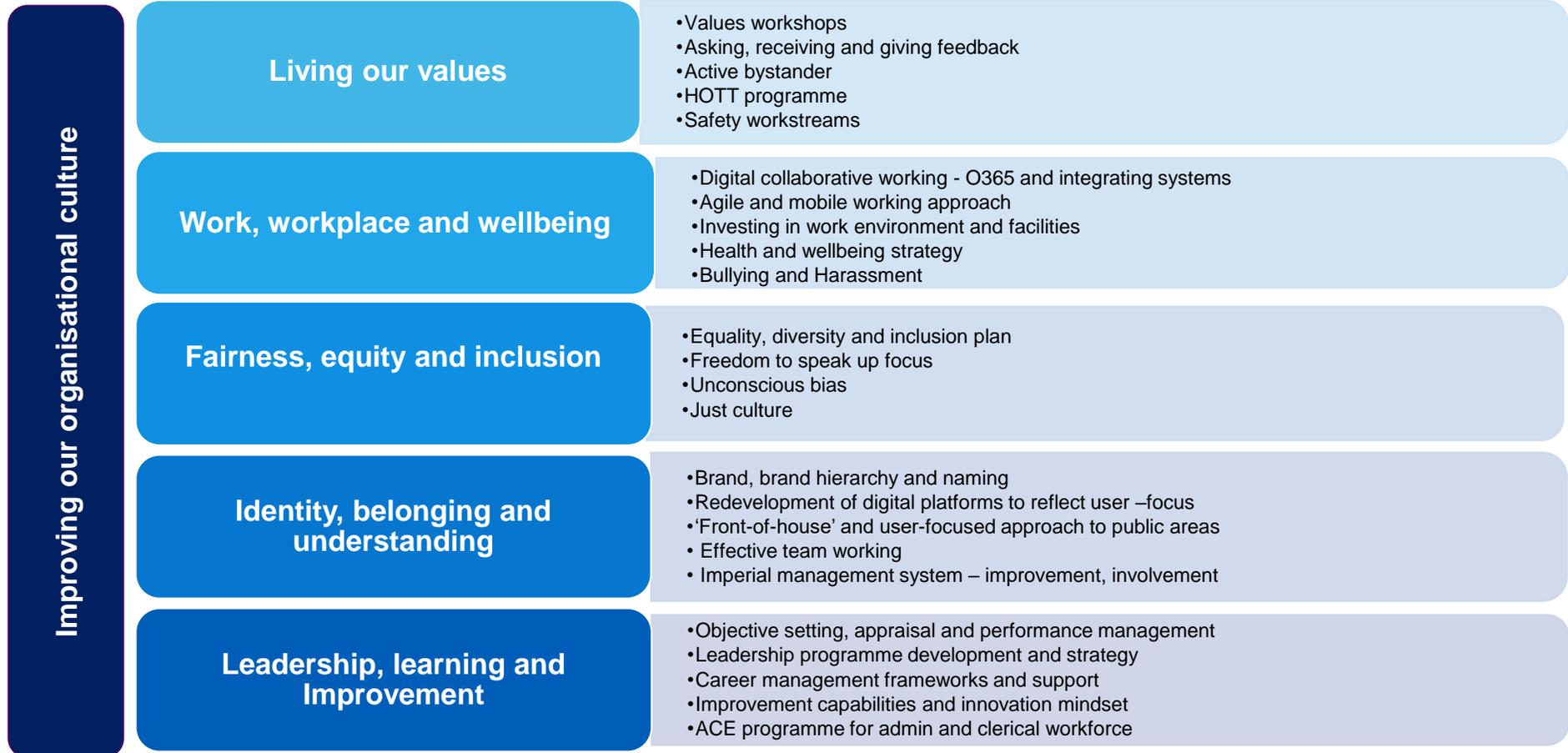
Areas of Focus

The results show that our lowest performing themes relate to 4 key areas, which should be the focus for action in 2020/21 at Trust level. Whilst they have all shown improvement compared to 2018, they have been consistently below the acute sector average.

Themes which are still below acute sector average	Trust score 2018	Trust score 2019	Acute sector average 2019
Equality Diversity and Inclusion	8.4	8.6	9.0
Health and well being	5.6	5.7	5.9
Morale	5.7	6.0	6.1
Staff environment – bullying and harassment	7.3	7.6	7.9

Going forward we need a more strategic approach reflecting the wide range of work affecting culture. The model below details the proposed Culture Programme

Culture Programme



Proposed matrix programme management structure recognising the distributed leadership responsibilities (work in progress)



	ExPod					ExDST	ExQual	ExDST
Group/ Committee	Culture Steering Group	EDI Committee	Leadership Faculty	Pathway to Excellence	Nursing and Midwifery Recruitment and Retention Steering group	Digital collaborative working steering committee	Safety improvement steering group	Improvement and Innovation
Exec Lead	Kevin Croft	Tim Orchard	Kevin Croft	Janice Sigsworth	Janice Sigsworth	Kevin Jarrold/ Michelle Dixon	Julian Redhead	Bob Klaber Claire Hook
Scope	Values Workshops Feedback training Active Bystander Investing in work environment and facilities Health and well being strategy Effective team working Appraisal and PDR	Equality Diversity and Inclusion Plan Unconscious bias	Leadership development and strategy Career management frameworks and support ACE programme	Leadership Reward and recognition Shared decision making	Nurse Retention initiatives	O365 Integrating systems	HOTT programme	Imperial management system Improvement capabilities and innovation



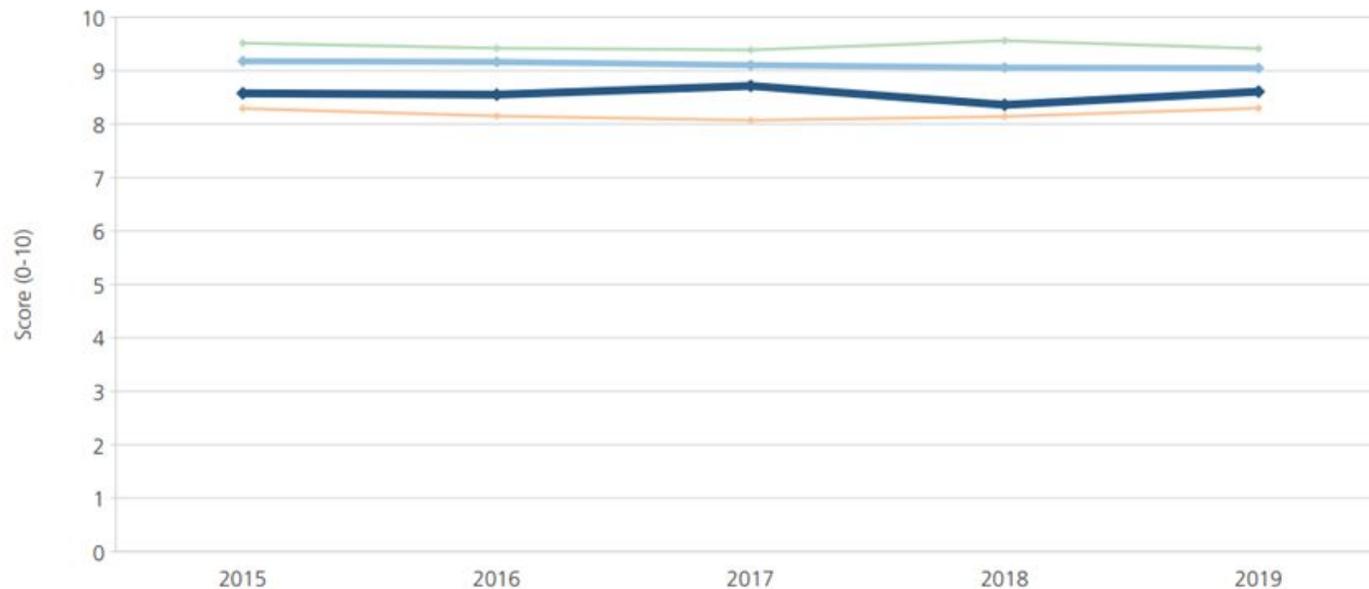
Appendix 1: Additional staff survey data tables for information

Equality Diversity and Inclusion: improved in the last year, however no significant improvement in the last 5 years, below national average

Survey
Coordination
Centre

2019 NHS Staff Survey Results > Theme results > Trends > Equality, diversity & inclusion

NHS
England



Best	9.5	9.4	9.4	9.6	9.4
Your org	8.6	8.6	8.7	8.4	8.6
Average	9.2	9.2	9.1	9.1	9.0
Worst	8.3	8.2	8.1	8.1	8.3
Responses	251	477	462	520	5,491

Equality, Diversity & Inclusion

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 1 – Equality, Diversity & Inclusion	8.37	8.56	 8.99
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	75%	77%	 84%
Experienced discrimination at work from patients / service users, their relatives or other members of the public in the last 12 months.	16%	 12%	 8%
Experienced discrimination at work from a manager / team leader or other colleagues in the last 12 months.	12%	10%	 8%
Has your employer made adequate adjustment(s) to enable you to carry out your work?	50%	 68%	 73%



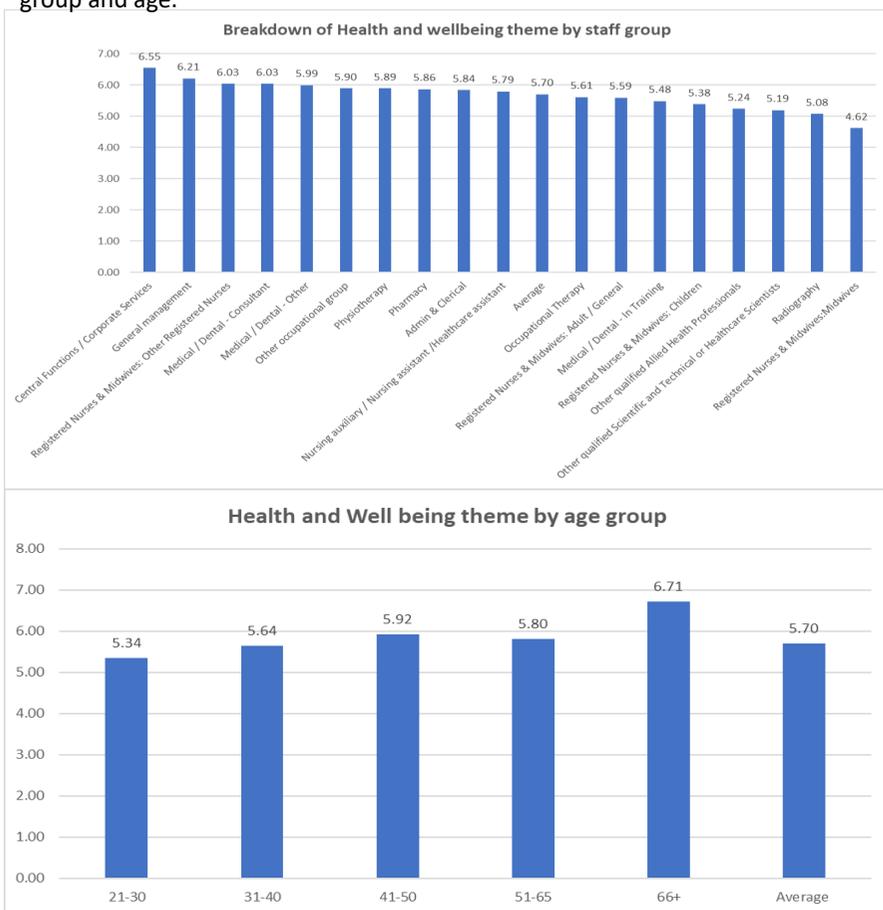
Health & Wellbeing

Quality Health

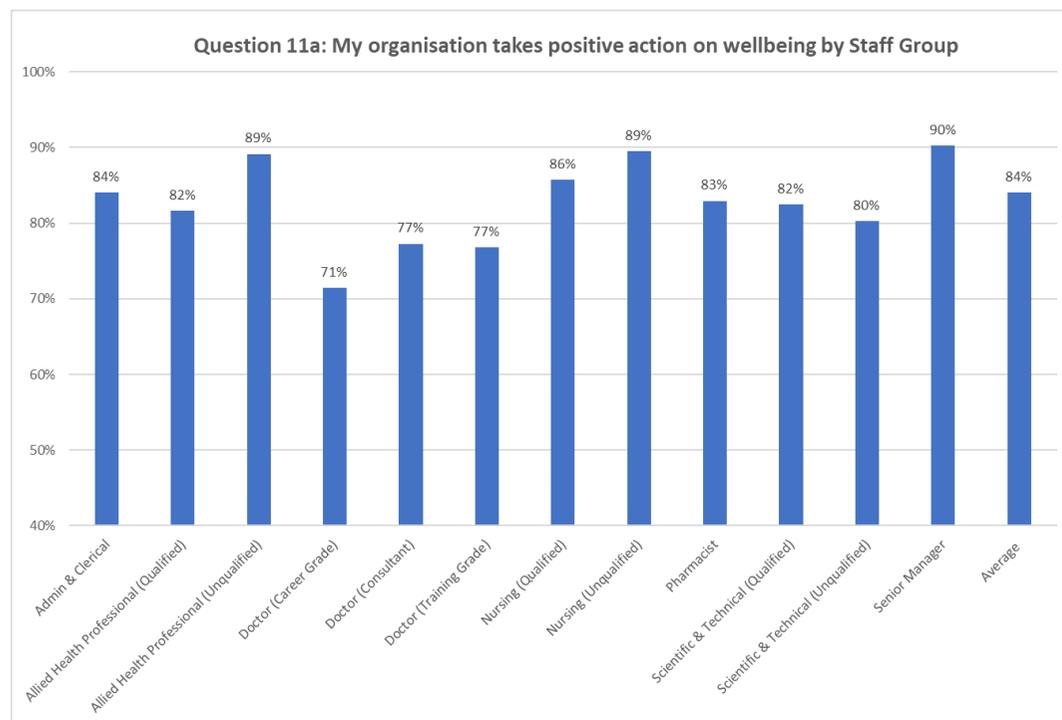
Theme/Question	Score 2018	Score 2019	Sector score
Theme 2 – Health & Wellbeing	5.56	5.67	 5.88
[How satisfied are you with] The opportunities for flexible working patterns?	52%	52%	 54%
Does your organisation take positive action on health and well-being?	82%	85%	 89%
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	30%	32%	 30%
During the last 12 months have you felt unwell as a result of work related stress?	43%	41%	 40%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	61%	57%	56%

Health and well being breakdown

The 2 charts below show a breakdown of the overall health and well being by staff group and age.



The chart below breaks down one key question on health and well being by staff group. The lowest results are reported by Doctors, (Career Grades, Training grades and Consultants). The most positive groups are senior managers, nursing and AHP unqualified





Immediate Managers

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 3 – Immediate Managers	6.58	6.94	6.84
[How satisfied are you with] The support I get from my immediate manager?	64%	 71%	70%
My immediate manager gives me clear feedback on my work.	59%	 64%	 62%
My immediate manager asks for my opinion before making decisions that affect my work.	55%	59%	 55%
My immediate manager takes a positive interest in my health and well-being.	64%	 69%	68%
My immediate manager values my work.	67%	 74%	72%
Did your manager support you to receive this training, learning or development?	95%	93%	 91%



Morale

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 4 – Morale	5.72	6.00	 6.14
I am involved in deciding on changes introduced that affect my work area / team / department.	52%	55%	 52%
I receive the respect I deserve from my colleagues at work.	69%	72%	72%
I have unrealistic time pressures.	34%	 29%	 32%
I have a choice in deciding how to do my work.	57%	54%	54%
Relationships at work are strained.	23%	 16%	17%

Morale (2)

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 4 – Morale	5.72	6.00	↓ 6.14
My immediate manager encourages me at work.	68%	↑ 72%	↑ 69%
I often think about leaving this organisation.	34%	↓ 27%	28%
I will probably look for a job at a new organisation in the next 12 months.	29%	26%	↑ 20%
As soon as I can find another job, I will leave this organisation.	24%	↓ 18%	↑ 14%



Quality of Appraisals

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 5 – Quality of Appraisals			
19a. Associated Question In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	91%	91%	 88%



Quality of Appraisals (2)

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 5 – Quality of Appraisals	5.83	5.90	 5.58
Did it (the appraisal, annual review, development review or KSF review) help you to improve how you do your job?	77%	77%	 72%
Did it (the appraisal, annual review, development review or KSF review) it help you agree clear objectives for your work?	87%	87%	 84%
Did it (the appraisal, annual review, development review or KSF review) it leave you feeling that your work is valued by your organisation	77%	77%	78%
Were the values of your organisation discussed as part of the appraisal process?	78%	 83%	 81%



Quality of Care

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 6 – Quality of Care	7.56	7.73	 7.44
I am satisfied with the quality of care I give to patients / service users.	85%	85%	 80%
I feel that my role makes a difference to patients / service users.	93%	92%	 90%
I am able to deliver the care I aspire to.	74%	76%	 68%



Safe Environment – Bullying & Harassment

Quality Health

Theme/Question		Score 2018	Score 2019	Sector score
Theme 7 – Safe Environment – Bullying & Harassment				
13d.	Associated Question The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	43%	47%	47%

Safe Environment – Bullying & Harassment (2)

Theme/Question	Score 2018	Score 2019	Sector score
Theme 7 – Safe Environment – Bullying & Harassment	7.26	7.61	7.90
Experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in the last 12 months.	37%	33%	 29%
Experienced harassment, bullying or abuse at work from managers in the last 12 months.	19%	 14%	 13%
Experienced harassment, bullying or abuse at work from other colleagues in the last 12 months.	26%	24%	 20%

Quality Health

Safe Environment – Bullying & Harassment (3)

13b. Managers.	2018		2019	
	n	%	n	%
Never	421	81%	4,706	86%
1-2	54	10%	500	9%
3-5	23	4%	157	3%
6-10	8	2%	59	1%
More than 10	11	2%	56	1%

13c. Other colleagues.	2018		2019	
	n	%	n	%
Never	380	74%	4,109	76%
1-2	81	16%	878	16%
3-5	31	6%	252	5%
6-10	11	2%	63	1%
More than 10	12	2%	95	2%



Safe Environment – Violence

Quality Health

Theme/Question		Score 2018	Score 2019	Sector score
Theme 8 – Safe Environment – Violence				
12d.	Associated Question The last time you experienced physical violence at work, did you or a colleague report it?	61%	63%	 66%

Quality Health

Safe Environment – Violence (2)

Theme/Question	Score 2018	Score 2019	Sector score
Theme 8 – Safe Environment – Violence	9.33	9.39	9.41
Experienced physical violence at work from patients / service users, their relatives or other members of the public in the last 12 months.	16%	15%	15%
Experienced physical violence at work from managers in the last 12 months.	1%	1%	1%
Experienced physical violence at work from other colleagues in the last 12 months.	2%	2%	2%

Quality Health

Safe Environment – Violence (3)

12b. Managers.	2018		2019	
	n	%	n	%
Never	505	99%	5,486	99%
1-2	3	1%	20	0%
3-5	0	0%	6	0%
6-10	1	0%	1	0%
More than 10	2	0%	3	0%

12c. Other colleagues.	2018		2019	
	n	%	n	%
Never	501	98%	5,305	98%
1-2	9	2%	88	2%
3-5	0	0%	10	0%
6-10	1	0%	5	0%
More than 10	2	0%	5	0%

2018 Staff Survey

RYJ : Imperial College Healthcare NHS Trust



Safety Culture

Quality Health

Theme/Question	Score 2018	Score 2019	Sector score
Theme 9 – Safety Culture	6.63	6.77	6.65
My organisation treats staff who are involved in an error, near miss or incident fairly.	59%	61%	↑ 59%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	70%	73%	↑ 69%
We are given feedback about changes made in response to reported errors, near misses and incidents.	62%	65%	↑ 59%
I would feel secure raising concerns about unsafe clinical practice.	69%	71%	70%
I am confident that my organisation would address my concern.	56%	59%	↑ 57%
My organisation acts on concerns raised by patients / service users.	72%	↑ 76%	↑ 72%



Additional – Job Satisfaction

Quality Health

Question		Score 2018	Score 2019	Sector score
3a.	I always know what my work responsibilities are.	90%	89%	89%
3b.	I am trusted to do my job.	91%	92%	92%
3c.	I am able to do my job to a standard I am personally pleased with.	79%	 85%	 80%
4e.	I am able to meet all the conflicting demands on my time at work.	49%	53%	 46%
4f.	I have adequate materials, supplies and equipment to do my work.	51%	 57%	 54%

2018 Staff Survey

RYJ : Imperial College Healthcare NHS Trust



Additional – Job Satisfaction (2)

Quality Health

Question	Score 2018	Score 2019	Sector score
4g. There are enough staff at this organisation for me to do my job properly.	34%	37%	 30%
4h. The team I work in has a set of shared objectives.	70%	73%	73%
4i. The team I work in often meets to discuss the team's effectiveness.	58%	61%	60%
5a. The recognition I get for good work.	53%	 58%	57%
5c. The support I get from my work colleagues.	76%	79%	 81%

Quality Health



Additional – Job Satisfaction (3)

Question		Score 2018	Score 2019	Sector score
5d.	The amount of responsibility I am given.	73%	74%	 75%
5e.	The opportunities I have to use my skills.	69%	72%	73%
5f.	The extent to which my organisation values my work.	45%	 51%	 47%
5g.	My level of pay.	30%	 36%	36%

Additional – Senior Managers Quality Health

Question	Score 2018	Score 2019	Sector score
9a. I know who the senior managers are here.	83%	 87%	 83%
9b. Communication between senior management and staff is effective.	43%	 50%	 41%
9c. Senior managers here try to involve staff in important decisions.	35%	 40%	 35%
9d. Senior managers act on staff feedback.	33%	 39%	 34%



Additional – Patient Feedback

Quality Health

Question	Score 2018	Score 2019	Sector score
22a. Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)	88%	90%	↑ 89%
22b. I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams)	63%	64%	↑ 62%
22c. Feedback from patients / service users is used to make informed decisions within my directorate / department.	57%	↑ 65%	↑ 58%

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q3 2019/20	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information
Date of Meeting: 25 March 2020	Item 13, report no. 10
Responsible Executive Director: Professor Julian Redhead, Medical Director	Author: Jon Otter, General Manager, IPC Professor Alison Holmes, Director, IPC Dr Eimear Brannigan, Deputy Director, IPC
Summary: <ul style="list-style-type: none"> • There have been 27 hospital-associated <i>C. difficile</i> cases during Q3; overall, there have been 80 cases during 2019/20, exceeding the annual target (of 77 cases). An investigation has not identified a clear reason for this increase and there has only been one lapse in care documented during 2019/20. • We are on target to meet our 10% year-on-year reduction in Trust-attributed <i>E. coli</i> BSIs (an internal performance metric). • The findings of the second national GIRFT SSI audit (data collected between April and October 2019) show that rates of SSI are below the national average for vascular and orthopaedic but above the national average for cardiothoracic. A task and finish group led by a consultant cardiothoracic surgeon is overseeing SSI risk reduction and an improved process for SSI surveillance. • Overall antimicrobial consumption rose during Q2 and Q3 2019/20, which was expected due to winter pressures; reductions in carbapenem consumption have been sustained. • During Q3, several clusters and outbreaks were identified and managed, including clusters of patients colonised with CPE on a medical ward, a private patients ward, and a surgical ward; a cluster of patients colonised with carbapenemase-producing <i>P. aeruginosa</i> on a medical ward; three patients with MSSA BSI in a satellite renal outpatient dialysis unit; these have prompted two SI investigations. There were also 23 communicable disease 'look back' investigations. • Emergency pathways were reviewed to ensure that preparedness for the management of highly pathogenic respiratory organisms (such as MERS and influenza) is optimal. • General Estates and water hygiene management issues continue to be challenging, with outstanding issues persisting in several clinical areas. 	
Recommendations: The Board is asked to note the report.	
This report has been discussed at: N/A	
Quality impact: IPC and careful management of antimicrobials are critical to the quality of care received by patients at ICHT, crossing all CQC domains. This report provides assurance that IPC within the Trust is being addressed in line with the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections' and related guidance.	
Financial impact: No direct financial impact.	
Risk impact and Board Assurance Framework (BAF) reference: This report includes a summary update of the IPC risk register.	
Workforce impact (including training and education implications): None.	
Has an Equality Impact Assessment been carried out? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable	
Trust strategic objectives supported by this paper: <ul style="list-style-type: none"> ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do 	

1 Healthcare-associated infection surveillance and mandatory reporting

- There have been 27 hospital-associated **C. difficile** cases during Q3 (22 Hospital Onset, Healthcare-Associated (HOHA) and 5 Community-Onset, Healthcare-Associated (COHA) against a ceiling of 18 HOHA and COHA cases combined (Appendix Table 1; Figure 1). Overall, there have been 80 cases of hospital-associated *C. difficile*, against a ceiling of 55 for the period April to December 2019/20. Only one of these cases had a lapse in care (in October 2019), meaning that there has been a single lapse in care case for the period April to December 2019/20, compared with eight lapses in care during 2018/19. The rate of hospital-associated (HOHA and COHA) *C. difficile* cases was the third highest in the Shelford group based on April to November 2019/20 cases.
- We have a comprehensive set of measures to minimise the risk of *C. difficile* infections. This includes multidisciplinary clinical review of all cases, rapid feedback of lapses in care to prompt ward-level learning, and *C. difficile* prevention ward rounds. In response to the increase in the number of hospital-associated *C. difficile* cases in 2019/20, we have investigated possible factors driving this. This has included a comparison of hospital-associated *C. difficile* cases during the time of increased incidence (April to November 2019, the latest available data at the time of the analysis) vs. the same period in the previous year when rates were comparable to the national average (April to November 2018). We also reviewed available comparable data from peer Trusts. At this point, neither changes in patient demographics, associated risk factors, nor an increase in lapses in care related to transmission or antibiotic choices explain the increase. Transmission was not prominent, and antimicrobial use was in accordance with Trust policy. Overall, antimicrobial use at Imperial is lower than it has been historically, with the antimicrobial point prevalence studies indicating a high degree of compliance with a suite of prescribing indicators. There is no clear difference in the distribution of cases by site in 2019/20. Therefore, it is not clear what is driving the observed increase in *C. difficile* cases. Further work around understanding whether changes in speciality-level prescribing and community prescribing explain *C. difficile* trends.
- There were no cases of Trust-attributed **MRSA bloodstream infection (BSI)** during Q3 from 8715 blood cultures tested. Compliance with MRSA admission screening was on target at 90% for Q3: 6932 of the 7678 patients identified as requiring MRSA screening were screened.
- There have been 11 cases of Trust-attributed **MSSA BSI** during Q3, compared with eight during Q3 2018/19. There is no national threshold for MSSA BSI. Three of these were associated with a central venous access device. These three cases occurred in a satellite dialysis unit, which was investigated as an IPC incident. Each case is reviewed by a multidisciplinary group (including the clinical team looking after the patient), and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases. This has prompted additional teaching on the wards in relevant areas around vascular access device care, record keeping and promoting contacting the vascular access team for support. There has been no evidence of patient-to-patient transmission.
- The number of Gram-negative **E. coli, Pseudomonas aeruginosa, and Klebsiella pneumoniae BSI** cases during Q3 2019/20 is summarised in Appendix Table 1. The Trust is on track to meet its 10% year-on-year reduction in Trust-attributed *E. coli* BSIs (an internal performance metric), with 61 cases for the period April to December 2019/20, compared with 68 cases for this period during 2018/19. Imperial's *E. coli* BSI rate ranks third lowest in the Shelford group.
- There were no Trust-attributed CPE BSI in Q3; a total of six cases have been identified so far in 2019/20, on par with six cases for the same period during 2018/19.
- Key developments and accomplishments towards supporting the government's ambition to halve healthcare-associated Gram-negative BSI by 2021 during Q2 2019/20 include:
 - Contribute to the NHS England / Improvement London-wide antimicrobial resistance (AMR) event focussing on Gram-negative BSI reduction in November 2019.
 - The monthly multidisciplinary group meetings continue to review *E. coli* BSIs. Members of the Northwest London CCG attend to promote collaborative working across acute and non-acute care.
 - Key stakeholders (including the Medical Director, IPC, Deputy Chief Nurse, Procurement Nurse, and quality improvement experts) have formed a group to review the current infrastructure and resourcing for the management of urinary catheters and patient hydration. Workstreams include:
 - An audit on urinary catheter management, conducted by the audit team.

- Developing improved surveillance systems for the identification of urinary catheter-associated BSI.
 - Analysis of antimicrobial point prevalence survey data to understand the frequency of urinary tract infection (UTI) indications over the last 2 years.
 - Participate in the AMR CQUIN around UTI management in patients aged over 65.
 - Interpreting the findings of a national audit of *E. coli* BSIs in patients with cancer with the *E. coli* Cancer Collaborative (a partnership of several NHS Trusts that provide cancer services).
- Plans for Q4 include:
 - Continue to support NWL CCGs in developing plans to reduce Gram-negative BSI.
 - Developing a series of interventions to improve urinary catheter management in order to prevent *E. coli* BSIs secondary to urinary catheter-associated UTI. This will include communications to staff around urinary catheter management and hydration, and working with the CCG to improve the antibiotic treatment of UTIs in the community by moving away from trimethoprim towards nitrofurantoin.
 - Planning of interventions aimed at preventing *E. coli* BSIs in patients with cancer following the findings of the national audit.
- The rate of **catheter line-associated BSI (CLABSI)** remains below benchmark rates in adult ICU, paediatric ICU, and in very-low birthweight babies in the neonatal ICU. There have been only four CLABSIs in the adult ICUs during Q3 (a rate of 1.4 per 1,000 line days), which is considerably below the benchmark rate of 3.6 per 1000 line days). The rate of 'contaminants'¹ also remains below the benchmark rate.
- Rates of **surgical site infection (SSI)** remain below national benchmark rates following the selected elective orthopaedic procedures included in the mandatory national surveillance scheme (Appendix Section 7.2). The SSI rate following CABG and non-CABG procedures remains consistently above the national average over the past 12 months. The cardiothoracic team have convened a bi-weekly Task and Finish group chaired by a cardiothoracic surgeon and including key stakeholders to urgently develop an action plan to reduce the risk of SSI following cardiothoracic procedures. This action plan has not yet been finalised but will be monitored through the *Surgical Infection Group*.
- We are building a new SSI surveillance and prevention team. An SSI nurse and SSI pharmacist will join in Q4 2019/20. The new team will begin by supporting the Divisions to embed prospective surveillance in the specialities identified as priority areas (Vascular, General surgery, Cardiothoracic, Neurosurgery, and Obstetric surgery). Then, surveillance will be rolled-out across all surgical specialities. This will allow us to understand and benchmark rates of SSI and target improvement work.
- The national *Getting It Right First Time (GIRFT)* prospective audit of SSI between May and October 2019 has now concluded (Appendix Table 2). The response to the high rate of SSI in cardiothoracic procedures is outlined above.
- The number of **carbapenemase-producing Enterobacteriaceae (CPE)** identified each month has plateaued at between 50 and 80 each month. More than 95% of these samples are from screening specimens rather than from clinical specimens.
 - Overall compliance with CPE admission screening was 83%, and >90% in the four specialties performing universal admission screening. CPE admission screening compliance is included by ward in the monthly *Harm Free Care* report. This provides a mechanism to prompt targeted improvement at ward level to address areas of low compliance.
 - A Cerner tool to offer decision support to frontline staff and to track and report on CPE admission screening compliance, including patients who declined to be screened, has been built in collaboration with *Chelsea and Westminster Hospital NHS Trust*. We are currently waiting for the date that this change will be implemented in Cerner.
 - A Trust-wide point prevalence screen of all inpatients to understand the CPE carriage rate across our inpatient population and inform our screening strategy, as recommended in the PHE guidance of 2013, was completed in September 2019. The results will be shared following completion of analysis during Q4.

¹ Bacteria identified in blood cultures that are associated with patients' skin and considered not to be representing infection. Benchmark for contaminated blood cultures set based on published literature, which suggests a rate of 3%: Self et al. *Acad Emerg Med* 2013; 20:89-97.

2 Antibiotic stewardship

- The next biannual antibiotic point prevalence study (PPS) (based on a review of inpatients) will be conducted in January 2020. For the first time, surgical prophylaxis will be included as a prescribing quality indicator.
- There was a rise in **antimicrobial consumption** during Q2 and Q3 2019/20 (Appendix Figure 3). In keeping with the trend from previous years, this rise was expected due to the winter month pressures on antimicrobials and due to the Trust's change in antimicrobial policy to incorporate more of the oral "ACCESS" group as recommended by PHE and WHO to curb the threat of resistance. We continue to prescribe fewer antimicrobials than the peak of prescribing four years ago.
 - Carbapenem-reduction initiatives that were introduced in Q1 have continued to curb usage and lower consumption has been successfully maintained through to Q3.
 - A rise in piperacillin/tazobactam use during Q3 2019/20 can be attributed to use within Critical Care and Haematology. Usage will be monitored closely in Q4 and work is underway to understand factors driving increased use, one of which may be the potential use of piperacillin/tazobactam as a carbapenem sparing agent. Work will also focus on continued de-escalation strategies and reducing course duration.
 - Compared with our Shelford peers, Imperial ranks third lowest for Piperacillin / Tazobactam usage but ranks third highest for carbapenem usage.
 - There has been a continual increase in the percentage of antibiotics from within the Access Group since its launch through to Q2. In Q3, the proportion decreased by 1% from Q2 to 44.2%; this is likely to have been accounted for by more broad-spectrum oral agents during the winter period. If this expected seasonal trend does not reverse, then further investigation and actions will be required.
- A new **Antibiotic Stewardship Dashboard** has been launched in Cerner. This system has allowed for a more targeted approach to antibiotic reviews and will be embedded in further antibiotic stewardship activities once ICT modifications have been completed in Q4 2019/20.
- We continue to experience the impact of **national antimicrobial shortages** for a number of agents (including antibiotics to treat tuberculosis, intravenous Amikacin, and intravenous Benzylpenicillin); this challenge is identified on the risk register. The Infection Pharmacy team is managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis. There is no evidence of patient harm as a result of these shortages.
- We are participating in the **NHSE Anti-fungal CQUIN** with 0.4 WTE 8a pharmacy support. This work is part of the wider *Medicines Optimisation CQUIN*.
- We are participating in the **Antimicrobial Resistance 2019/20 CQUIN**. Preliminary Q3 data shows an overall compliance of 39% with the CQUIN indicators for the management of lower urinary tract infections (UTI) in the elderly (compared with 9% in Q2), and an overall compliance of 66% with appropriate use of antibiotic surgical prophylaxis in colorectal surgery (compared with 47% in Q2).
- Work to improve the identification and management of sepsis continues through the **Sepsis Big Room**. Work is ongoing to improve the recording of fluid balance and to introduce the sepsis alert to paediatrics and maternity. We are currently working on an enhanced communication approach to ensure that the key messages are received by key staff. Final changes have been made to the QlikView app, which will be going live for all ward managers and other clinical staff during Q4. This will allow ward staff to review local sepsis-related indicators for their clinical areas.

3 Hand hygiene and Aseptic Non-Touch Technique (ANTT) competency assessment

- We have a requirement that **ANTT competency assessment** is undertaken and documented for all clinical staff. Currently the compliance rate is 82.8% (6973/8423 clinical staff), below our 90% target. Plans are in place to improve compliance along with other core clinical skills.
- The next bi-annual **hand hygiene** compliance audits are scheduled for April 2020, which will encompass the use of patient surveys to gather information on hand hygiene practice from selected clinical areas where conventional observational audit is not feasible (such as outpatient wards).
- A celebration and shared learning event for the hand hygiene improvement focus wards took place in December 2019. The focus was on success stories from Phase I and II wards. The 'Golden Hand' award for the most improved area was presented to Victor Bonney ward. The event was extended to staff from Phase III wards as part of the shared learning initiative.

- The Phase III focus wards have commenced their improvement cycle. IPC diagnostic huddles are in place to focus on issues specific to each clinical area. Planning for phase IV is underway: learning from Phases I-III has identified repeated core systemic issues that need to be addressed in order to enhance the hand hygiene improvement work (for example, hand hygiene practice in certain staff groups). The outline proposal for phase IV is to have a combined programme with a smaller number of focus wards along with specific project work aimed at tackling particular staff groups / issues.
- We have developed and piloted a novel hand hygiene awareness campaign, using song lyrics to provide “nudge” hand hygiene reminders to staff. The posters were installed before the end of January 2020 and evaluated on the phase III focus wards.

4 Clinical activity, incidents, and lookback investigations during Q3

- Three clusters of CPE and one of carbapenemase-producing *P. aeruginosa* were identified and managed. These clusters included four patients colonised with carbapenemase-producing *P. aeruginosa* in a medical ward, three patients colonised with CPE on a medical ward, three patients colonised with CPE on a private patients ward, and nine patients colonised with CPE on a vascular surgery ward.
- Three MSSA bloodstream infections were identified in three patients attending a satellite dialysis unit in October and November 2019. One patient has died with MSSA bacteraemia featuring on the death certificate. A full investigation into IPC practice, cleaning and the environment has been undertaken and actions are now in place focusing on vascular access device management. Typing indicates that there was no person-to-person transmission. This was reported as a serious incident, which is under investigation.
- Emergency pathways were reviewed to ensure that preparedness for the management of highly pathogenic respiratory organisms (such as MERS and influenza) is optimal.
- In Q3, a total of 23 communicable disease ‘look back’ investigations were undertaken related to potential exposures to tuberculosis, chickenpox, shingles, meningitis, measles, mumps, hepatitis A and invasive group A streptococcal infection. This has increased slightly from 19 during Q2.

5 Compliance, policies, and risks

- Issues with **cleaning** and **estates** standards continue to be identified. Facilities have reviewed cleaning policies and processes in conjunction with the Divisions and IPC in order to improve cleaning and disinfection standards. A new cleaning contract is in the process of tendering.
- We have two tiers of annual **core skills IPC training**: Level 1 for all staff and Level 2 for clinical staff. Compliance with Level 1 is 93% and 90% for Level 2. These improvements are in line with increases in compliance in all core skills, which is an output of focussed efforts by Divisions and Corporate services supported by the core skills team.
- There have been no new **IPC risks** identified. Updated risks include:
 - The risk related to negative pressure isolation rooms at the Charing Cross site has been updated to include challenges with negative pressure rooms in the ICU at Hammersmith.
 - The water hygiene management risk has been updated to reflect ongoing challenges with water hygiene management.
 - The risk related to poor standards of cleaning has been updated to reflect continued issues with the Trust’s cleaning contractor.
 - The accepted risk related to poor practice around vascular access had previously become an ‘accepted risk’ (reviewed less frequently than ‘live risks’). However, this risk has been made live to reflect challenges in meeting increased demand for the vascular access service.

6 Other

- Members of the IPC team have produced 5 peer-reviewed **publications** relating to applied research in HCAI and AMR during Q3.

7 Appendix

7.1 Healthcare-associated infection surveillance and mandatory reporting

	Apr-19		May-19		Jun-19		Jul-19		Aug-19		Sep-19		Oct-19		Nov-19		Dec-19		Jan-20		Feb-20		Mar-20		YTD		
	No. cases	Ceiling	No. cases	YTD	YTD (ceiling)																						
Trust MRSA BSI	0	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Hospital onset- Hospital associated (HOHA)	3	-	7	-	10	-	6	-	6	-	5	-	9	-	6	-	7	-	-	-	-	-	-	-	-	59	-
Community onset-Hospital associated (COHA)	2	-	2	-	1	-	6	-	4	-	1	-	1	-	1	-	3	-	-	-	-	-	-	-	-	21	-
Total Hospital associated C.difficile cases (HOHA + COHA)	5	8	9	7	11	6	12	6	10	5	6	5	10	5	7	6	10	7	-	-	-	-	-	-	80	55	
Trust <i>Escherichia coli</i> BSI	8	-	6	-	5	-	8	-	3	-	5	-	10	-	9	-	7	-	-	-	-	-	-	-	-	61	-
Trust MSSA BSI	2	-	1	-	1	-	5	-	2	-	1	-	3	-	3	-	5	-	-	-	-	-	-	-	-	23	-
Trust CPE BSI	0	-	0	-	2	-	1	-	3	-	0	-	0	-	0	-	0	-	-	-	-	-	-	-	-	6	-
Trust <i>Pseudomonas aeruginosa</i> BSI	2	-	4	-	2	-	5	-	4	-	2	-	5	-	3	-	5	-	-	-	-	-	-	-	-	32	-
Trust <i>Klebsiella</i> BSI	2	-	3	-	6	-	3	-	10	-	5	-	5	-	5	-	3	-	-	-	-	-	-	-	-	42	-

'Trust' refers to cases that are identified after two days of hospitalisation and so are defined epidemiologically as "hospital-acquired". A further delineation is made for C.difficile whereby non-Trust toxin (EIA)-positive cases where the patient has had a previous hospitalisation within 4 weeks are classified as 'Community Onset-Hospital Associated (COHA), distinguishing it from 'Hospital Onset-Hospital Associated' (HOHA) cases. National thresholds are set for MRSA BSI and C. difficile infection.

Table 1: HCAI mandatory reporting summary.

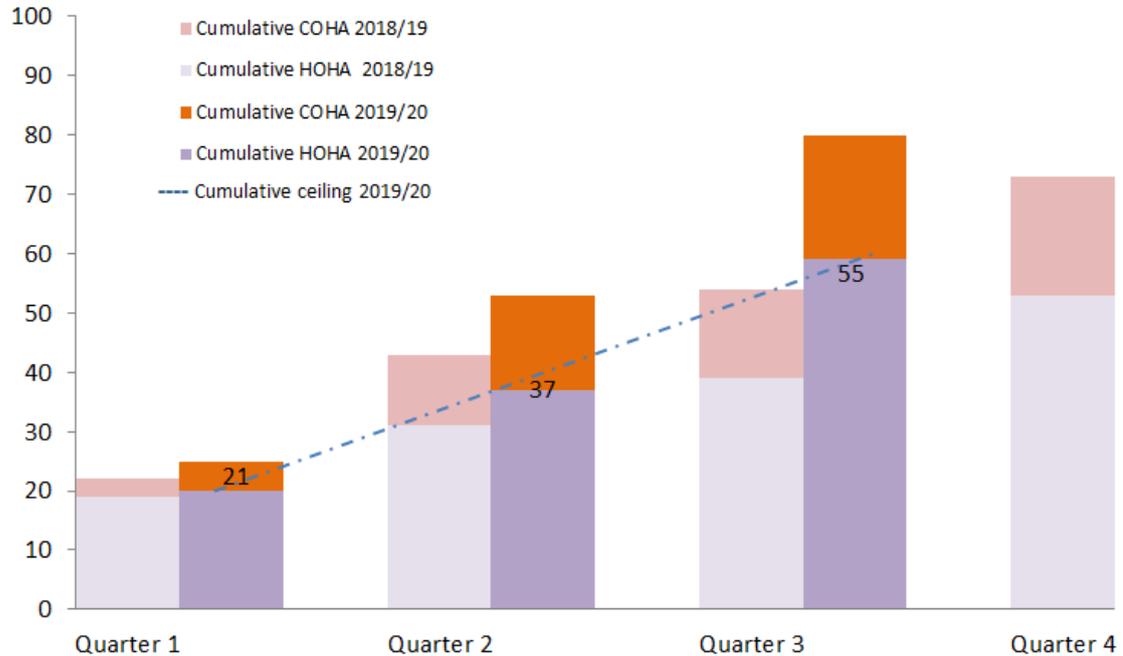


Figure 1: Cumulative hospital-associated C. difficile cases, by quarter 2019/20 (dark purple bars = HOHA, orange bars = COHA) compared with the corresponding categories in 2018/19 (light purple bars = HOHA, light orange bars = COHA).

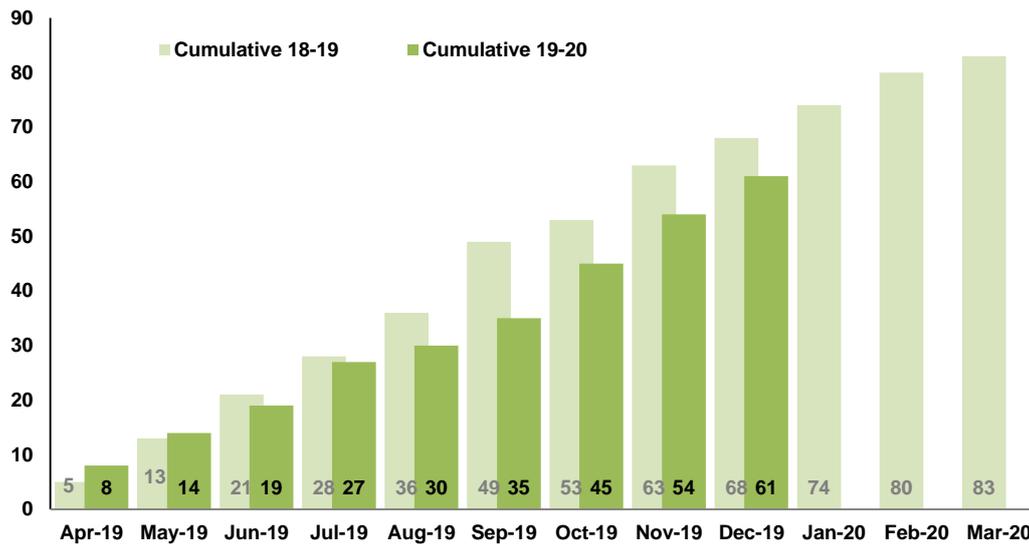


Figure 2: Cumulative monthly 2019/20 Trust-attributed E. coli BSI (dark green bars) compared to 2018/19 (light green bars).

7.2 Surgical site infection

7.2.1 Orthopaedics

The latest quarter with finalised submitted data (Jul-Sept 19 finalised data) has seen:

- Knee procedures: 0 SSI in 105 procedures; 12-month average is 0.3% (1 SSI in 370 operations); national average is 0.6%.
- Hip procedures: 0 SSI in 71 procedures; 12-month average is 0% (0 SSI in 278 operations), national average is 0.6%.

7.2.2 Cardiothoracic

The latest quarter with finalised submitted data (Jul-Sept 19 finalised data) has seen:

- CABG: six SSI (8.3%) of 72 procedures; 12-month average is 7.2% (19 SSI in 265 procedures); national average is 3.8%. All six were superficial incisional SSIs.
- Non-CABG: three SSI (6.5%) of 46 procedures; 12-month average is 3.8% (6 SSI in 156 procedures); national average is 1.3%.

7.2.3 GIRFT SSI audit results

GIRFT speciality	Overall SSI rate	PHE 5-yr national average
Cardiothoracic	6.8%	3.8%
Vascular	2.4%	2.5%
Orthopaedics	0.3%	0.6%

Table 4: GIRFT speciality SSI rates against PHE National average

7.3 Antimicrobial stewardship

7.3.1 Antimicrobial consumption

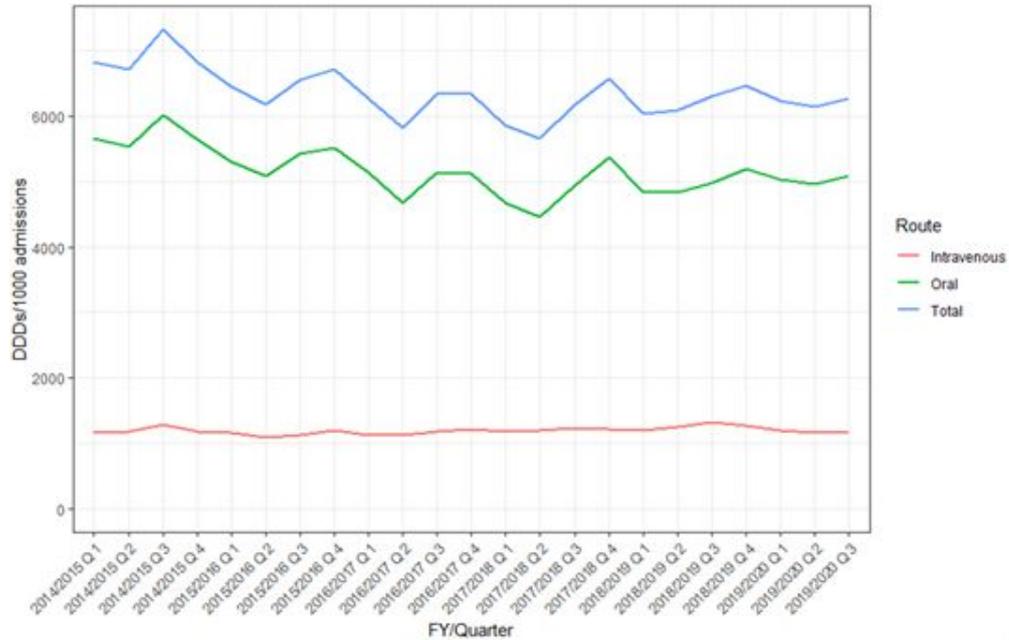


Figure 3: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration.

**TRUST BOARD - PUBLIC
 SUMMARY REPORT**

Title of report: Audit, Risk & Governance Committee – report from meeting on 10 March 2020	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information/noting
Date of Meeting: 25 March 2020	Item 14.1, report no. 11a
Responsible Non-Executive Director: Sir Gerald Acher, Deputy Chair	Author: Jessica Hargreaves, Deputy Trust Secretary
<p>Summary:</p> <p>The Audit, Risk and Governance Committee met on 10 March 2020. Key items to note from that meeting include:</p> <p>External Audit</p> <p>The Committee received a verbal update on external audit, noting that the planning for 2020/21 had gone well and Committee members were pleased to note improved collaborative working. It was noted that there were no new issues causing concern from the external auditor's perspective apart from the impact of COVID-19, which would be monitored closely as information becomes available.</p> <p>Internal audit progress report</p> <p>Committee members noted the internal audit progress report and were pleased to note that the Trust was on plan to deliver the 2019/20 audit plan with a vast majority already completed. The Committee noted the organisational learning audit and actions and management update on progress with these. The Committee also noted the data quality and safeguarding workforce internal audit reports. The Committee received and reviewed the draft plan for 2020/21 which was being finalised with the executive team.</p> <p>Local Counter Fraud Service (LCFS) and National Fraud Initiative Update</p> <p>Committee members received an update on progress against the 2019/20 counter fraud plan and were pleased to note that the Trust was on schedule to complete the plan by 31 March. The draft self-review toolkit was due to be submitted by 30 April and would be signed off by the Chief Finance Officer and Chair of the Audit Committee. The Committee received and noted the counter fraud plan for 2020/21. Committee members also received the national fraud initiative (NFI) update and noted that the Trust was making reasonable progress and was in the process of recovering duplicate payments.</p> <p>Corporate risk register, key risks and board assurance framework</p> <p>The Committee noted the corporate risk register, key risks and board assurance framework. Particular focus on the risks relating to the corona virus were discussed and Committee members were assured that a robust pandemic plan was in place, and whilst there was substantive pressure operationally, the Trust was managing it at the present time; a risk assessment on the impact of this was being worked through by the executive and would be added to the risk register. Noting the risk management aspect, it was noted that mobile working would need to be put in place quickly, but that delegated authority did not need to be changed at this time.</p> <p>Non-emergency patient transport performance update</p> <p>Committee members were pleased to note that performance from the provider of the non-emergency patient transport was steadily improving and that the transport provider and Trust staff were working</p>	

collaboratively. The next area of focus would be to look at scheduling transport for renal patients in a better way and this was in progress. It was agreed that the continued quality and performance management would be overseen by the Quality Committee.

Sustainable development management plan

The Committee welcomed the work that had taken place to pull the sustainable development management plan together and agreed to recommend it to Trust board on 25 March 2020, for approval.

Tender waiver & Losses and special payments reports

The Committee received and noted a summary of the number of tender waivers since April 2019 and the controls in place.

The Committee will next meet on Wednesday 22 April 2020.

Recommendations: The Trust Board are requested to note this report.

TRUST BOARD - PUBLIC BOARD SUMMARY

Title of report: Report from Quality Committee – report from meeting held on 18 March 2020	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information/noting
Date of Meeting: 25 March 2020	Item 14.2, report no. 11b
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	Author: Amrit Panesar, Corporate Governance Assistant
<p>Summary:</p> <p>The Quality Committee met on 18 March 2020. Key items to note from that meeting include:</p> <p>Matters arising The committee noted that work on the response to the Patterson report were ongoing but that private practice was regulated as tightly as NHS work. Following the Board away day, a review of the work of the Committee was planned in the near future</p> <p>Update on COVID-19 This was the main item on a shortened agenda, necessitated so as not to impinge on the Executive CoVID meeting. The Committee received oral reports on the Trust's response to the COVID-19. The Committee noted the actions currently taken by the Trust to address the national emergency of the Coronavirus. The Committee noted that the situation was fluid and fast-moving, and that responses had to be operationally led. The non-Executives were very keen to offer any help and support that would be useful. The Committee was deeply impressed with the quality of the approaches being taken, and hugely grateful to the CEO, the Executive team, and all staff working on this crisis for their superb leadership</p> <p>Integrated Quality and Performance Report The Committee noted the quality aspects of the performance report.</p> <p>Incident Monitoring Report Committee members noted that reporting rate for January 2020 was above target and the number of patient safety incidents has increased to 1,699 compared with 1,487 in December 2019. Serious incidents were declared during January, 18 of which were treatment delays due to a lack of availability of mental health beds. The Committee were pleased to note that monitoring safety and quality remained a very high priority despite necessary CoVID19 actions.</p> <p>Key Divisional Quality Risks The Committee noted that Divisional Directors and Corporate Directors risks were largely focusing on the COVID-19.</p> <p>(The remainder of the Agenda took the form of papers which were noted but not discussed in detail)</p> <p>Never events action plan update The Committee noted from the papers that one never event was declared in January 2020.</p> <p>Implementation of the Medical Examiner Service The Committee noted from the papers that the implementation of the Medical Examiner Service had made very good and significant progress with this programme of work, and was on track to have an operational service in place by April 2020.</p>	

North West London Pathology Operational Performance and Governance Report

The Committee noted from the papers that in January 2020, no new pathology related serious incidents were reported. The Committee members noted that the Trust's mortuary services have been transferred back to the Trust on 1st March 2020.

Flu update

The Committee noted from the papers that the flu campaign for this year has been completed. The Trust's uptake figure is 69.2%.

Pressure Ulcers report

The Committee received a detailed report relating to the number of Trust acquired three and unstageable pressure ulcers over the last two years. When compared nationally, there is a very low level of pressure damage occurring at the Trust.

National Maternity Survey Outcome

The Committee noted the results following the National Maternity Survey Outcome. Overall rating the Trust was about the same as expected and comparable to other London and shelford Trusts.

National Children and Young People Survey outcome

The Committee noted the results following the National Children and Young People Survey outcome.

CQC Update

The Committee noted that in response to the COVID-19 CQC has suspended all hospital inspections.

Quality Account Priorities for next year

The Committee agreed the Quality Account Priorities for next year, aligned to the proposed Trust-level Focused Improvements, identified via business planning and the development of IMIS:

- **Improve FFT Response Rate**
Improving the quality of feedback provided in the FFT responses to feed the natural language processing tool to better understand the positive and negative experiences of patients.
- **Improve % of staff who feel they are able to make improvements in their area**
Targeting support at low response areas to understand their top contributing reasons why they feel they are unable to make improvements in their area and supporting improved engagement and capabilities in improvement initiatives.
- **Improve incident reporting rate**
Improving incident reporting rates to bring focus to safety and quality priorities, and to the Trust's values and behaviours framework, to create a patient-centred culture.
- **Reduce temporary staffing spend**
Creating a safe and sustainable workforce by focusing on the top areas with high temporary staffing spend, understanding their root causes and supporting them through our Safe and Sustainable Staffing workstreams.
- **Reduce number of patients with a length of stay of 21 days or more**
Improving our bed occupancy performance, and therefore timely access for patients requiring a bed, by reducing the number of medically fit patients with a length of stay of 21 days or more.
- **Reduce avoidable harm to our patients.**
Reduce avoidable harm through continuing, reviewing and refining our nine safety streams and refining these to launch our Safety Improvement Programme.

Recommendations:

Trust Board is asked to note this summary.

TRUST BOARD – PUBLIC BOARD SUMMARY

Title of report: Report from the Finance, Investment and Operations Committee meeting held on 3 and 18 March 2020	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information/noting
Date of Meeting: 25 March 2020	Item 14.3, report no. 11c
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	Author: Jessica Hargreaves, Deputy Trust Secretary
<p>Summary: The Finance Investment & Operations Committee met on 3 March and 18 March 2020. Key items to note from those meetings include:</p> <p>Financial planning The Committee met on 3 March 2020 to consider the draft financial plan prior to submission to NHS Improvement on 5 March, following initial discussion at the Board seminar on 26 February. The Committee noted the financial planning to date, including a planning gap to achieve the control total for 2020/21, and agreed to submit a plan showing off-trajectory against the control total but to signal the Trust ambition to achieve the trajectory by 29 April.</p> <p>Financial performance including CIP performance and recovery plan Committee members noted the finance report for month 11, and were pleased to note that the Trust was on plan year to date and on track to meet the control total at year end. Committee members discussed at length the current crisis relating to COVID-19. Noting the operational impact this was having on the organisation, it had been confirmed that all costs would be fully funded by the centre. Committee members acknowledged that there would be a loss of income, including a significant amount of private patients income which would have an impact on the financial position of the Trust going into 2020/21, but agreed the importance of managing the organisation on a day to day basis at present, ensuring that patients and staff were kept as safe as possible and were glad to hear that money was not a restraint in managing the healthcare response to the pandemic.</p> <p>Business planning process The Committee noted that the business planning process continued internally, but that submissions to NHSE/I were on hold in light of the current national response to COVID-19. Work to agree a baseline from 1 April was in progress.</p> <p>Managed maintenance service contract extension The Committee agreed to recommend to the Trust board, to approve the extension of the managed maintenance service contract with the current provider for a further five years.</p> <p>Hotel services update The Committee were pleased to note progress on the programme of work to move hotel services in-house.</p>	
<p>Recommendations: To note this summary.</p>	

TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Board Redevelopment Committee 4 March 2020	<input type="checkbox"/> Approval <input type="checkbox"/> Endorsement/Decision <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information/noting
Date of Meeting: 4 March 2020	Item 14.4, report no. 11d
Responsible Non-Executive Director: Paula Vennells, Committee Chair	Author: Ginder Nisar, Deputy Trust Secretary
<p>Summary:</p> <p>The inaugural Board Redevelopment Committee met on 4 March 2020 and agreed the revised proposed governance arrangements for the Trust Redevelopment Programme.</p> <p>The Committee received an update from the Programme Director on key activities since joining the Trust, and updates on key workstreams.</p> <p>The Committee reflected on the discussion at the Programme Board regarding the private patients project, outlining a proposed ambition for the Imperial Private Healthcare business over the coming 10 years into implications for redevelopment planning.</p>	
<p>Recommendations:</p> <p>To note this summary.</p>	